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**Scottish Midwives 1916-1983:  
The Central Midwives Board for Scotland  
and Practising Midwives**

**by**

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A thesis submitted for the degree of PhD to the University of Glasgow.

Centre for the History of Medicine and the School of Nursing and Midwifery.

October 2002

## **Declaration**

I declare that I composed this thesis by myself. The research on which it was based was my own work.

Lindsay Reid

## **Abstract**

The purpose of this thesis is to explore how differing circumstances came together to help or hinder the autonomous practice of midwives in Scotland between 1916 and 1983 when the Central Midwives Board (CMB) oversaw their training and practice. The thesis includes an examination of the records of the CMB for Scotland from 1916 to 1983 and, through oral testimonies, the work of practising midwives during the same period.

The thesis is divided into two parts. Part I, comprising five chapters, explores the work of the CMB from 1916 to 1983. This includes: an examination of the issues surrounding the 1902 Midwives Act which did not apply to Scotland, and the campaign for, and opposition to, a similar Act for Scotland, passed in 1915; the constitution and early activities of the CMB which the 1915 Midwives (Scotland) Act established to oversee the enrolment, training and practice of midwives; a discussion of the national concern over the Maternal Mortality Rate in the 1920s and 1930s, subsequent Government reports and legislation and the CMB's responses to these issues; an examination of the CMB's work during the time of World War II, the shortage of midwives, and the changes the National Health Service administration made to midwifery in Scotland. Finally, Part I examines the last decades of the CMB's existence, including its response to changes in midwifery management, education, practice and statute.

Part II, comprising three chapters, focusses on the practice of midwives in Scotland during the period through the aspects of antenatal, intranatal and postnatal care. Each chapter uses evidence from oral testimonies of midwives working within the framework established by relevant Acts and the CMB. Part II illuminates the contrast between the work of the CMB and the world of hands-on midwifery practice.



The 1915 Midwives (Scotland) Act officially recognised midwives as a group, gave them a legal identity, and status as autonomous practitioners. However, its provisions affected this autonomy. During the period under examination, midwives' ability to be autonomous practitioners fluctuated within the frameworks which regulated their education and practice.

Within the period of the CMB's existence the education of midwives improved. Nevertheless, the CMB, a product of the implementation of the 1915 Midwives (Scotland) Act and the essential body for the oversight of midwifery in Scotland, perpetuated the hierarchical customs of the day. Thus, throughout most of its existence, the CMB's influence prevented midwives from achieving parity with those with whom they worked: it kept midwives firmly in a role subordinate to GPs and obstetricians. In addition, through its Rules and strict supervision it delayed the development of autonomous midwifery practice.

However, improved education of midwives gradually brought an increase in confidence. In an endeavour to evaluate the level of midwifery autonomy lost, gained or maintained, the thesis reveals the developing confidence of the midwife of the 1980s but suggests that to capitalise on this, midwives require the goodwill and confidence of themselves, other professionals and women with whom they work.

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I also acknowledge the National Board for Scotland for Nursing, Midwifery and Health Visiting for Scotland (NBS) and its successor, NHS Education for Scotland, for giving me permission to consult the Records of the CMB at the NAS. I should like to thank particularly Beatrice Grant, former Professional Officer (Midwifery) NBS for her

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## Abbreviations

ADM	Advanced Diploma in Midwifery
AMH	Aberdeen Maternity Hospital
BMA	British Medical Association
CMB	Central Midwives Board for Scotland
CMB (E&W)	Central Midwives Board for England and Wales
CRAG/ SCOTMEG	Clinical Resource and Audit Group / Scottish Management Executive Group
DHS	Department of Health for Scotland
DHSS	Department of Health and Social Security
DRI	Dundee Royal Infirmary
DVT	Deep venous thrombosis
EAG	Educational Advisory Group
EN	Enrolled Nurse
EOS	Edinburgh Obstetrical Society
EEC	European Economic Community
GMC	General Medical Council
GP	General Practitioner
GRMH	Glasgow Royal Maternity Hospital
GRO(S)	General Register Office for Scotland
GUL	Glasgow University Library
IOM	Inspectors of Midwives
IMR	Infant Mortality Rate.
JNMCNI	Joint Nursing and Midwives Council Northern Ireland

LA	Local Authority
LGBS	Local Government Board for Scotland
LSA	Local Supervising Authority
MMR	Maternal Mortality Rate.
MOH	Medical Officer of Health
NAS	National Archives of Scotland
NBS	National Board for Scotland for Nursing, Midwifery and Health Visiting for Scotland. (Initially, Scottish National Board , SNB).
NICNM	Northern Ireland Council of Nursing and Midwifery
PPH	post partum haemorrhage.
QVJIN	Queen Victoria Jubilee Institute for Nurses
RCM	Royal College of Midwives
RCS Ed.	Royal College of Surgeons of Edinburgh
RFN	Registered Fever Nurse
RGN	Registered General Nurse
RJCC	Refugees Joint Consultative Committee.
RSCN	Registered Sick Children's Nurse
SBH	Scottish Board of Health
SCM	State Certified Midwife
SEN	State Enrolled Nurse (England and Wales)
SMA	Scottish Midwives' Association
SHHD	Scottish Home and Health Department
SNB	Scottish National Board
SOS	Secretary of State, in this case, for Scotland

SOM	Supervisor of Midwives
UK	United Kingdom
VOL	Vale of Leven Hospital
WRHB	Western Regional Hospital Board



## Glossary

Anent	concerning, about.
Blue Book	pupil midwife's case book required by the CMB for Part 2 midwifery.
DOMINO	Domiciliary in and out: community midwife care for a hospital delivery and home six hours later.
Dunny	dungeon, area under a tenement.
Gallipot	metal sterilisable bowl-shaped container.
Green Lady	Glasgow Municipal Midwife, called Green Lady because of the green uniform. Glasgow health visitors also wore green and were also known as Green Ladies. However, for the purpose of this thesis, Green Lady refers to midwife.
Howdie	uncertified midwife.
Infant mortality rate	The IMR is defined as the number of infants dying within one year of birth per 1000 live births per year. <sup>1</sup>
Lochia	the term used to describe the discharges from the uterus during the puerperium.
Maternal mortality rate	The MMR is defined as the number of deaths due to pregnancy and childbirth per 1,000 total births (live and still) per year. <sup>2</sup>
Neonatal mortality rate	The NMR is defined as the number of infants dying within twenty-eight days of birth per 1,000 live births per year. <sup>3</sup>
Para	in this context, describing the number of babies a woman has given birth to, for example, para 1=had one baby.
Parous	describing a woman who has had a baby previously.
Perineal area/ Perineum	area of the body situated between the vagina and the rectum.
Perinatal mortality rate	The PMR is defined as the number of stillbirths and babies who die in the first week of life per 1,000 total births (live and still) per year. <sup>4</sup>

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<sup>1</sup> Educational Advisory Group of the Scottish Board of the Royal College of Midwives, Social and Statistical Facts for Student Midwives, (London: Pitman Books Limited, 1982), p 83.

<sup>2</sup> Ibid, p 79.

<sup>3</sup> Ibid, p 82.

Prim, primigravida	a mother who is pregnant for the first time.
Rooming in	system of care in a maternity unit where babies stay with the mothers all the time.
Rottenrow	Glasgow Royal Maternity Hospital.
Sic	such (Scots)
Slunge, slungeing	terms used, mainly in hospitals, to describe work done in the sluice area of a ward.
Syntocinon	artificial oxytocin used intravenously to induce or augment labour.
Syntometrine	a drug comprising syntocinon and ergometrine used to assist and speed up the third stage of labour.

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<sup>4</sup> Ibid, p 81.

# Scottish Midwives 1916-1983:

## The Central Midwives Board for Scotland and Practising Midwives

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## Introduction

The autonomous practice of midwives in Scotland for the care of women undergoing a normal childbearing episode has been approved by statute since the 1915 Midwives (Scotland) Act. Before that date, women who practised as midwives did so not illegally, but without state regulation. The majority were untrained and took the title 'midwife' by repute rather than by any specific education they received. The provisions of the Act permitted midwives to practise independently and make their own professional decisions. Yet, long before 1915 the autonomy of midwives was subject to limitations. Prior to the mid-eighteenth century, midwives cared for and delivered women in childbirth; male medical practitioners were called in emergency situations, such as prolonged labour, malposition of the fetus and haemorrhage. From the mid-eighteenth century, the presence of male practitioners in the delivery room became more common even for normal births.<sup>1</sup>

The 1915 Midwives (Scotland) Act established a Central Midwives Board (CMB) to oversee the registration (known at the time as 'enrolment'), training and practice of midwives; the CMB continued until 1983. While the Act brought the first formal recognition of midwives as a group throughout Scotland and gave them a legal identity, in practice, its provisions affected their autonomy.<sup>2</sup> Throughout the period from 1916 to 1983 the identity and autonomy of midwives were subject to negotiation and change, both in terms of the institutional frameworks within which they trained and practised, and the nature of their practice before, during and after birth.

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<sup>1</sup> J Donnison, *Midwives and Medical Men*, (New Barnet: Historical Publications, 1988), p 34.

<sup>2</sup> V Fleming, 'Autonomous or Automaton? An exploration through history of the concept of autonomy in midwifery in Scotland and New Zealand' in *Nursing Ethics*, 5 (1), 1998, p 46.

By the use of the words 'autonomous' and 'autonomy' I do not wish to imply that midwives should take up an isolationist stance. Midwifery can no more be totally independent than can the medical profession, nor any other group who would work with others within a team framework. The words 'autonomous' and 'autonomy' can indicate independence but also indicate a freedom: in this case, the freedom of midwives to determine their own actions or behaviour when practising normal midwifery; and the freedom of the profession to make its own decisions over, for instance, education and practice. This is an autonomy which enables one professional group to co-operate with others on an equal basis. Thus parity and respect for the opinions and practice of others within the framework can be maintained.

On the eve of the 1915 Act, midwives in Scotland had no unifying organisation nor, despite some sporadic local attempts to license and educate midwives, was there any formal regulation of their practice.<sup>3</sup> Some had attended lectures and trained in maternity hospitals; some were trained nurses (although nursing at that time was also an unregulated profession); most relied on experience on the job ranging from delivering a baby as a neighbourly act to gaining a reputation in an area through watching and learning from another uncertified midwife, known in Scotland as a howdie. Most births (estimated at 95 per cent) of both the rich and the poor took place at home, though a few, especially in the cities, took place in maternity hospitals which evolved in Scotland from the second half of the eighteenth century.<sup>4</sup> There was little or no antenatal care which

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<sup>3</sup> A Cameron, 'Licensed to Practise within their Bounds': The Faculty of Physicians and Surgeons and the Regulation of Midwives in Eighteenth Century Glasgow, presented at History of Nursing Research Colloquium, Oxford Brookes University, 18 March, 2000; D Dow, The Rottenrow: The History of the Glasgow Royal Maternity Hospital 1834-1984, (Carnforth: The Parthenon Press Ltd, 1984), p143.

<sup>4</sup> J M Munro Kerr, 'The Maternity Services', in J M Munro Kerr, R W Johnstone, M R Phillips, Historical Review of British Obstetrics and Gynaecology 1800-1950, (Edinburgh and London: E&S Livingstone Ltd, 1954), p 3; Dow, The Rottenrow, p 14.



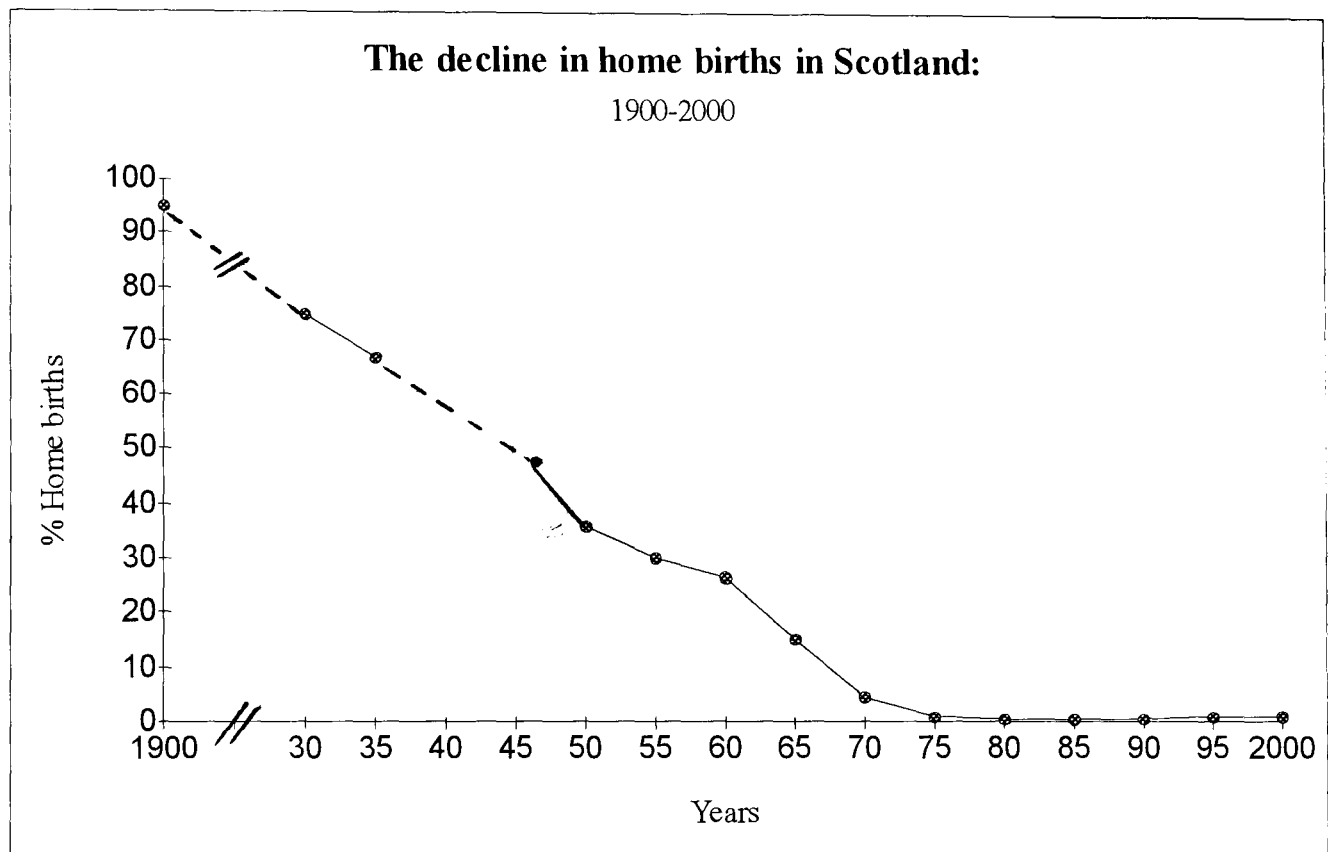
meant that potential problems went un-noticed until the mother went into labour and called out the midwife. Although postnatal care was part of the midwife's duty, especially immediately post-delivery, it also was unregulated and of varying standards.<sup>5</sup>

By 1983 the CMB, comprising sixteen members, of which a statutory seven were midwives, oversaw a well-established system of registration, training and practice. However, care of pregnant, labouring and postnatal women and their babies was largely under the control of the medical profession even though midwives were legally autonomous professionals and that women were legally entitled to choose the type of care they wanted. This paradox led to tensions between obstetricians, general practitioners (GP), midwives and women. The change from home to hospital, as the recommended place of birth during the period under examination, appears to be a crucial element in the changing position of midwives. The graph below demonstrates the decline in home births in Scotland and is based on the data in Appendix 5. The changing place of birth in Scotland appears to correlate with the medicalisation of childbirth and the loss of autonomy of the midwife. As childbirth became more medicalised, affecting all areas of maternity care, midwives found themselves in the dilemma of obeying hospital policy and protocols rather than acting as autonomous practitioners.<sup>6</sup>

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<sup>5</sup> J Watson, A Complete Handbook of Midwifery for Midwives and Nurses, 3<sup>rd</sup> Edition (London: The Scientific Press Limited, 1914), p 287.

<sup>6</sup> J Garcia, R Kilpatrick, and M Richards, eds, The Politics of Maternity Care, (Oxford: Clarendon Press, 1990), p 2; R Mander, 'Autonomy in Midwifery and Maternity Care', Midwives Chronicle, October, 1993, pp 369-374; pp 369-374; for a definition of medicalisation in this context see below, p 14.

**Figure Intro 1**

Key: --- estimate

Note: There is no data from the mid-1930s until 1946

Source: Data in Appendix 5

The purpose of this thesis is to explore the ways in which long-term changes in the care of pregnant and childbearing women, short-term events, other professions, and midwives themselves, came together to reduce or facilitate the autonomous practice of midwives in Scotland between 1916 and 1983 when the CMB oversaw their training and practice.

## Previous Literature

While the history of midwives and their practice in England and Wales, the United States and Europe has attracted a number of historians, very little has been written from a

Scottish perspective. The history of midwives and their practice in twentieth century Scotland has not attracted the interest of historians or midwives, apart from Lesley Diack's dissertation covering an earlier period, a brief reference in Improving the Common Weal and Derek Dow's The Rotten Row: The History of Glasgow Royal Maternity Hospital 1894-1984.<sup>7</sup> In addition, Valerie Fleming's article on the autonomy of midwifery in Scotland and New Zealand is pertinent to this thesis as it briefly discusses the constraints the medically dominated CMB placed upon newly-enrolled midwives.<sup>8</sup> Recent research into maternity care in Scotland particularly the work of Tricia Murphy-Black, Rosemary Mander, and Janet Askham and Rosaline Barbour is also relevant, although their main focus is on the end of the twentieth century.<sup>9</sup>

A brief examination of the available literature from countries other than Scotland highlights many potential parallels and contrasts, in both practice and statute. The emergence of the man-midwife in the 18<sup>th</sup> century and the uneasy relationship between midwives and the male medical profession in England provide the focus for major studies by Jean Donnison, Jane Donegan and Adrian Wilson.<sup>10</sup> Donnison traces changes in the

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<sup>7</sup> Diack, H L, Women, Health and Charity: Women in the Poor Relief Systems in eighteenth century Scotland and France, unpublished PhD thesis, (Aberdeen: University of Aberdeen, 1999); G McLachlan, ed, Improving the Common Weal: Aspects of Scottish Health Services 1900-1984, (Edinburgh: Edinburgh University Press, 1987); D Dow, The Rottenrow: The History of the Glasgow Royal Maternity Hospital 1834-1984, (Camforth: The Parthenon Press, 1984).

<sup>8</sup> Fleming, 'Autonomous or Automaton?' p 46.

<sup>9</sup> T Murphy-Black, 'Care in the Community during the Postnatal Period', S Robinson and A Thomson eds Midwives, Research and Childbirth, Vol 3, (London and Glasgow: Chapman and Hall, 1994), pp 120-146; T Murphy-Black, 'Systems of Midwifery Care in Use in Scotland', Midwifery, 8, 1992, pp 113-124; R Mander, Change in Employment Plans, Midwifery, 3, 1987, pp 62-71; R Mander, Midwifery Training and Employment Decisions of Midwives, Midwifery, 8, 1992, pp 233-259; J Askham, and R Barbour, 'The Role and Responsibilities of the Midwife in Scotland', in E van Teijlingen *et al*, Midwifery and the Medicalization of Childbirth: Comparative Perspectives, (New York: Nova Science Publishers, Inc, 2000) pp 173-178; J Askham, and R Barbour, 'The Negotiated Role of the Midwife in Scotland', in S Robinson, and A Thomson, eds, Midwives, Research and Childbirth, Vol 4, (London and Glasgow: Chapman and Hall, 1996,) pp 33-59.

<sup>10</sup> J Donnison, Midwives and Medical Men, (New Barnet: Historical Publications, 1988); J Donegan, Women and Men Midwives, (Westport, Connecticut: Greenwood Press Inc 1978); A Wilson, The Making of Man-Midwifery, London: University College London Press, 1995.

role and work of midwives from early times, the coming of men into the birthing chamber, firstly for prolonged or complicated births and their gradual presence into the world of normal midwifery. She describes the contesting of occupational boundaries between midwives and medical men, the competition for cases between medical practitioners and midwives and the opinion of some midwives, that, if things went wrong in male hands, an accoucheur would find a way of blaming the midwife if she were there. The rivalry continued into the twentieth century and members of the General Medical Council and other medical men opposed regulation of midwives for many years before the 1902 Midwives Act for England and Wales. Some midwives, too, opposed the Bill. They saw registration and the projected plans of governance by a Board mainly staffed by medical men as a removal of much of their autonomy. Donnison discusses attempts to give local licences in midwifery in Edinburgh and Glasgow, but she does not mention the 1915 Midwives (Scotland) Act nor does she acknowledge the differences in legislation, education and practice between the two systems.<sup>11</sup>

The development of man-midwifery affected not only midwives but mothers as well and Jane Donegan and Adrian Wilson deal with both aspects. Both authors describe personalities and practices associated with the advent and spread of men in the field of childbirth. They agree on the important events and individuals in the narrative of the emergence of man-midwives. However, the two authors diverge on the reasons why certain key situations developed as they did.

Jane Donegan acknowledges the impact of male practitioners on difficult childbirth. She then goes on to the surprising development of men's domination of normal childbirth in an era known for its modesty, arguing that the male ownership of

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<sup>11</sup> Donnison, Midwives and Medical Men, pp 50, 48, 140.

women, either as male midwives or husbands was important for understanding this paradox. Coming from a pro-women and pro-midwife stance, she also examines the reform movements of those who used this paradox of prudishness and male midwives to try and turn midwifery back to the midwives.<sup>12</sup> She also describes situations where the public, midwives, and other doctors appeared to lose no opportunity to denigrate the accoucheurs. Charlotte Borst, in her Catching Babies, focussing on midwives in America and the change to physician-attended childbirth, does not refer to Donegan, but her criticism of historians dealing with this subject applies: 'some polemical histories of this subject depict physicians at the turn of the twentieth century as scheming sexists, conniving to push midwives out of their rightful place at birthing women's bedsides'.<sup>13</sup>

In contrast to Donegan who concentrates on the power of male practitioners, Adrian Wilson, focussing largely on London, argues that eighteenth-century women were pro-active in the development of man midwifery in normal childbirth.<sup>14</sup> Linking the physical act of childbirth and the professionals involved with the social and cultural mores of the day, Wilson is concerned to explain why eighteenth century practitioners acted the way they did, rather than judge them by modern criteria. Wilson contends that the new class of literate women evolving from the middle of the eighteenth century broke up the collectivity of women and this new independence was part of the trend away from their use of midwives.<sup>15</sup> His description of the customs surrounding the birthing room is very vivid. However he leans heavily on the idea of the importance of the collectivity of women as a demonstration of women's strength, and he maintains that 'male

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<sup>12</sup> Donegan, Women and Men Midwives, p 6.

<sup>13</sup> C Borst, Catching Babies, (Harvard: Harvard University Press, 1995), p 9.

<sup>14</sup> Wilson, The Making of Man-Midwifery, p 6.

<sup>15</sup> Ibid, p 186.

practitioners were turned into midwives not by their own desire but through the choices of women'.<sup>16</sup>

The issue of males at childbirth was therefore more complex than that of male doctors *versus* female midwives. Ornella Moscucci reinforces the arguments of Borst and Wilson in her work on gynaecology and gender in England.<sup>17</sup> She shows that the development of gynaecology was not simply an example of men's oppression of women but had a much more complicated background. For example, there was conflict over which group, surgeons or physicians, should be responsible for obstetrics and gynaecology, and conflict over women's use and choice of hospitals. Thus, Moscucci supports the argument that women as well as gynaecologists had an active part to play in the establishment of the specialism. They consulted gynaecologists and, to a certain extent, dictated which hospital they would support. Doreen Evenden adds her voice to the discussion on hospitals and midwives, both male and female, indicating the complexity of the relationships. Contrary to the usual assumption that seventeenth century midwives were ignorant and unskilled, she demonstrates that these educated, respected midwives were knowledgeable in the art of midwifery.<sup>18</sup> However, she acknowledges the rise of the male midwife in the eighteenth century, citing the use and development of the London lying-in hospitals as the main factor in the demise of the female midwife.

At the beginning of the twentieth century antenatal care as it is known today was non-existent in Britain. In The Captured Womb Ann Oakley charts the development of

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<sup>16</sup> *Ibid*, p 192.

<sup>17</sup> O Moscucci, The Science of Woman, Gynaecology and Gender in England, 1800-1929, (Cambridge: Cambridge University Press, 1990).

<sup>18</sup> D Evenden, The Midwives of Seventeenth Century London, (Cambridge: Cambridge University Press, 2000).

antenatal care in Britain until the 1980s.<sup>19</sup> She argues that the medical profession used antenatal care as a strategy for the social control of women and the first eighty years of the twentieth century saw pregnancy become a distinct type of social behaviour under its jurisdiction.<sup>20</sup> She also argues that as increasingly midwives were recruited from the nursing profession, this marked ‘the beginning of the end of British midwifery as a profession concerned with the *normal* physiology of childbearing’.<sup>21</sup> Oakley points to the loss of status of midwives in England and Wales who were ‘in danger of becoming mere handmaidens to obstetricians’.<sup>22</sup> She is in no doubt that up until the 1980s, regardless of research, statistics and evaluation, the professionals who carried most weight were obstetricians: they were the providers who carried most prestige and political power. As Oakley suggested, this was also the case in Scotland.

The history of midwifery is closely related to the history of maternal mortality. Irvine Loudon in his book Death in Childbirth, explores issues of maternal care and mortality and examines the effectiveness of maternal care internationally between 1800 and 1950. Loudon’s aims are to establish the nature and extent of maternal mortality, and to a lesser extent, perinatal infant death, and to extend knowledge of the development of the professions related to pregnancy and childbirth. The work deals with international statistics and statistical problems to do with the study of maternal mortality rates (MMR). These included: changes in rules of registration; differences in registration in differing countries; what constituted a maternal death; and problems classifying an ‘associated

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<sup>19</sup> A Oakley, The Captured Womb, (Oxford: Basil Blackwell Publisher Ltd, 1984).

<sup>20</sup> Ibid, p 4.

<sup>21</sup> Ibid, p 110.

<sup>22</sup> Ibid, p 76.

death' and multiple causes of death. Countries varied in their methods of recording statistics and accurate international comparisons are difficult to achieve.<sup>23</sup>

Loudon deals with the causes of maternal mortality including standards of living, the effect of poverty on maternal mortality and pathological reasons for maternal mortality. He also links maternal mortality with maternal care. Regulation of, and attitudes to midwives varied from country to country and in most countries of early nineteenth-century continental Europe, midwives were licensed by the state or local government. This contrasted sharply with British midwives who were denigrated by the medical profession bitterly opposed to their registration. Danish midwives were, and are, held in very high regard with a professional status which enabled them to work with medical practitioners on a reciprocal footing. In Sweden, although untrained midwives existed in some areas until the early twentieth century, regulation of midwives was established in 1663. They developed a formal working relationship with doctors with little of the animosity found between British medical practitioners and midwives. Midwifery training prospered and in nineteenth century Sweden, as on the rest of the Continent, great importance was placed upon midwifery regulation which led to more formal training.<sup>24</sup> Also, in the Netherlands, well known for its tradition of high standards of midwifery education dating from 1818, the status of midwives was high. Home births with the midwife as the lead professional remain a prominent part of maternity care. From 1900 to 1936-37 the MMR in Sweden, the Netherlands, Norway and Denmark was consistently better than that of England and Wales and of Scotland, although by 1950, the gap had narrowed significantly. Although there were other reasons for the lowering of the

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<sup>23</sup> Loudon, *Death in Childbirth*, pp 23, 25, 28, 34.

<sup>24</sup> *Ibid*, pp 43, 424, 425, 422, 406.



MMR, Loudon's representation of the trends in maternal mortality in various countries demonstrates clearly the connection between good midwifery education and respect for midwives, on the one hand, and lower levels of MMR on the other. Using the Netherlands and England and Wales as examples, Loudon suggests that the marked decline in maternal mortality in the Netherlands in 1900 was due to 'the high standard of trained midwives and the better standard of obstetric education for doctors in the Netherlands'.<sup>25</sup>

Another historian concerned with comparisons between continental and British midwifery is Hilary Marland who examined aspects of midwives' lives and work, and maternal and infant welfare from the early modern period until the late twentieth century.<sup>26</sup> Marland has made a particular study of midwifery in the Netherlands and her chapter on the growing importance of the midwife in eighteenth century Holland illustrates the difference of regard in which midwifery in Holland and in Britain was, and is, held. Other work with which she is associated demonstrates the variations between midwifery, the work of midwives and care of women in childbirth internationally and in Europe including England and Wales in the modern period.<sup>27</sup> This work puts particular emphasis on differences in legislation among countries and suggests the importance of focussing on the history of midwifery in Scotland with its separate history of legislation regarding midwives.

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<sup>25</sup> *Ibid*, pp 417, 152, 402-407, 444.

<sup>26</sup> Marland, H, ed, *The Art of Midwifery*, (London: Routledge 1993).

<sup>27</sup> Marland, H, 'The *'burgerlijk'* midwife: the *stadsvroedvrouw* of eighteenth century Holland', in H Marland, ed, *The Art of Midwifery*, pp 192-215; V Fildes, L Marks and H Marland, *Women and Children First, International Maternal and Infant Welfare, 1870-1945*, (London and New York: Routledge, 1992); H Marland, and A M Rafferty, eds, *Midwives, Society and Childbirth*, (London: Routledge, 1997).

The issues of maternal mortality, care for childbearing women and the nature of the professionals in the field in Britain in the twentieth century were not only the focus of state regulation and intra-professional interests, but also voluntary organisations.

Susan Williams provides a detailed record of the activities of the National Birthday Trust Fund (NBTF) which was founded in 1928 with the reduction of the MMR as its main objective.<sup>28</sup> The organisation threw its weight behind the idea of maternity care professionals working together. It was particularly keen to improve the status of midwives and took an active part in the formation of the Joint Council of Midwifery (JCM) whose report was instrumental in the formation and passing of the 1936 Midwives Act in England and Wales. Williams, however, does not mention the 1937 Maternity Services (Scotland) Act, the equivalent Scottish Act to the 1936 Act, which had a more comprehensive remit.

As part of her evidence, Williams uses previously unpublished oral testimonies. That this is an effective way of illuminating the history of midwives is further demonstrated by Nicky Leap and Billie Hunter who trace the evolution of midwifery practice and training in the first half of the twentieth century through oral history testimonies and their analysis.<sup>29</sup> Their findings have many parallels with midwifery in Scotland. However, while Leap and Hunter use the term 'Britain', none of the interviewees they quote is from Scotland and the dates of the Midwives Acts they cite are those for England and Wales.

Oral testimony and statistical analysis make an important contribution to the discussion of issues surrounding the autonomy of midwives and the best location for

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<sup>28</sup> A S Williams, *Women and Childbirth in the Twentieth Century*, (Stroud: Sutton Publishing, 1997).

<sup>29</sup> N Leap and B Hunter, *The Midwife's Tale* (London: Scarlet Press, 1993).

childbirth. Julia Allison in Delivered at Home examines the work of district midwives in Nottingham from 1948 to 1972 and highlights their autonomy in practice.<sup>30</sup> Her findings contrast with the views of Dingwall, Rafferty and Webster who argue that, contrary to popular opinion, there was no ‘Golden Age’ of British midwifery.<sup>31</sup> Allison’s conclusions are also in contrast to Oakley, who argued that although midwifery appeared to be on the ascendency in the 1930s, in reality this was not so. Allison’s views stressing the autonomy of midwives in practice are supported by the testimony which I collected from Gelda Pryde, a Scottish midwife who worked in Nottingham during part of the time that Allison covers.

During the weekend...you were on call for the whole of the City of Nottingham... So you were delivering lots...of patients that you had never seen until you actually went to them in labour... there was very little involvement by medical staff on the district... Very few [GPs] ever came to a delivery and... the midwives...had direct admission rights to the local hospital so we could...send any patients in if...things were going wrong. The GPs didn’t really interfere. I don’t recall a GP ever doing a delivery while I was there.<sup>32</sup>

Pryde continues her oral testimony by highlighting differences in midwifery practice between England (as experienced in Nottingham) and Scotland. She raises questions of midwives’ confidence in Scotland and contrasts midwives’ and doctors’ attitudes to each other in England and in Scotland. She suggests that midwives in Scotland in the 1960s and 1970s lacked the confidence to discuss patients with doctors on an equal footing.<sup>33</sup>

One of the major changes in the twentieth century was the change in the location of childbirth. Whether the shift from home to hospital was good for mothers remains

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<sup>30</sup> Allison, J, Delivered at Home, (London: Chapman and Hall, 1996).

<sup>31</sup> Dingwall, Rafferty and Webster, An Introduction to the Social History of Nursing, (London: Routledge, 1988).

<sup>32</sup> Oral Testimony. For details of the oral interviews conducted in relation to this research, see Appendix 4. LR, 42 [69].

<sup>33</sup> See chapter 7 p 262.

controversial, but there is general agreement that it has had a negative impact on midwives' autonomy and status. Current research into midwifery practice in Britain indicates that the arguments for and against differing places of birth have major implications for midwives.<sup>34</sup> Marjorie Tew associates the diminishing of midwifery as an autonomous profession in twentieth century Britain with the development of more medical interventionist practices, more pain relief in labour linked with more mothers delivering in hospital.<sup>35</sup> With these changes, midwives in the late twentieth century had a continuing struggle to maintain a measure of independence and faced challenges as great as they were at the beginning of the century.<sup>36</sup>

The phrase 'medicalisation of childbirth and midwifery' epitomises these challenges. Van Teijlingen *et al* defined this term as,

the increasing tendency of women to prefer a hospital delivery to a home delivery, the increasing trend toward the use of technology and clinical intervention in childbirth, and the determination of medical practitioners to confine the role played by midwives in pregnancy and childbirth, if any, to a purely subordinate one'.<sup>37</sup>

In short, medicalisation of childbirth and midwifery featured: hospital delivery with associated use of technology and clinical intervention; and a limited and subordinate role for midwives. In their book on comparative international perspectives on medicalisation of childbirth, van Teijlingen *et al* show how the status of the midwife and the childbirth

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<sup>34</sup> R Campbell and A Macfarlane, Where to be Born? The Debate and the Evidence (Oxford: National Perinatal Epidemiology Unit, 1994); C Stringer, 'Review of Where to be Born? The Debate and the Evidence', Midwives, July 1995, p 226.

<sup>35</sup> M Tew, Safer Childbirth? A Critical History of Maternity Care, 2<sup>nd</sup> ed, (London: Chapman and Hall, 1995); H Marland, 'Childbirth and Maternity', in R Cooter and J Pickstone, Medicine in the Twentieth Century, (Amsterdam: Harwood Academic Publishers, 2000), pp 559-574.

<sup>36</sup> S Robinson, 'Maintaining the Independence of the Midwifery Profession: A Continuing Struggle', in J Garcia, R Kilpatrick and M Richards, The Politics of Maternity Care (Oxford: Clarendon Press, 1990), p 86.

<sup>37</sup> E van Teijlingen, G Lewis, P McCaffery, M Porter, Midwifery and the Medicalization of Childbirth: Comparative Perspectives, (New York: Nova Science Publishers, Inc, 2000), p 1.

process relate to the structure of society. They argue that while in some countries medicalisation of childbirth seems nearly complete, in others, a reverse trend is taking place both in childbirth and midwifery care specifically and in doctor-patient relationships generally.<sup>38</sup> One chapter relating to midwifery in Scotland points to the extensive medicalisation of childbirth and associated de-skilling of midwives, under-utilisation of midwives' skills, and consequent loss of motivation and confidence.<sup>39</sup> Other work on the role and responsibilities of the midwife in Scotland shows how some midwives in Scotland in the 1980s negotiated a role within the maternity team which, while still restricted in many clinical settings, enabled them to regain a reasonable level of job satisfaction, and at the same time give mothers a good standard of care.<sup>40</sup>

Like Donnison, Jean Towler and Joan Bramall survey the history of midwifery in England up to modern times in Midwives in History and Society.<sup>41</sup> By the 1980s, they argue, some GPs and obstetricians were joining midwives in their anxiety over the increasing medicalisation of childbirth and calling for change.

In the face of the pressures on their autonomy and identity, midwives in Scotland as elsewhere created organisations which attempted to respond. The Scottish Midwives' Association (SMA) started in 1917 under the leadership of a Lanarkshire midwife, Mrs Quintin Smith. Between 1917 and 1945 the SMA's membership grew to 300 with five branches. It was prepared to lobby MPs at Westminster when the need arose, for instance before the 1937 Maternity Services (Scotland) Act.<sup>42</sup> It also corresponded with the CMB when appropriate and responded to requests for evidence from Government committees,

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<sup>38</sup> *Ibid*, p 2.

<sup>39</sup> Askham, and Barbour, 'The Role and Responsibilities of the Midwife in Scotland', pp 173-178.

<sup>40</sup> Askham, and Barbour, 'The Negotiated Role of the Midwife in Scotland', pp 33-59.

<sup>41</sup> J Towler and J Bramall, Midwives in History and Society, London: Croom Helm, 1986).

for example the Salvesen Committee, and requests for help and support from midwives in Scotland.

The, originally English, College of Midwives was an older organisation which began through the work of Zepherina Veitch who qualified as a midwife in 1873 with the London Obstetrical Society.<sup>43</sup> Fired by the poverty of the London slums, the conditions in which mothers had to give birth, and the need to improve this by proper training and legislation of midwives, Veitch and her journalist friend, Louisa Hubbard, drew up a scheme for the Matrons' Aid, or Trained Midwives' Registration Society in 1881. Five years later this became the Midwives' Institute.<sup>44</sup> The lobbying and persistence of the Midwives' Institute played a large part in getting the first Midwives' Act through Parliament in 1902. The Midwives' Institute was made the College of Midwives in 1941 (its Diamond Jubilee year) as an acknowledgement of its importance in promoting and carrying out the training of midwives.<sup>45</sup>

The SMA amalgamated with the College of Midwives in 1946 eventually being awarded the accolade 'Royal' in 1947 forming the Royal College of Midwives (RCM). The RCM through the years has been consistent in working for the maintenance of professional recognition of midwives and the acknowledgement of the separate and distinct character of midwifery. However the RCM's success in doing this is arguable. Midwives at the beginning of the twenty-first century are still struggling for autonomy.

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<sup>42</sup> A Grant, The Royal College of Midwives, unpublished paper, undated.

<sup>43</sup> B Cowell and D Wainwright, Behind the Blue Door: The History of the Royal College of Midwives, 1881-1981, (London, Baillière Tindall, 1981), p 12,

<sup>44</sup> A Grant, 'The RCM – The first 100 years: some things never change', Midwives Chronicle, October 1981, pp 348-350.

<sup>45</sup> Cowell, and Wainwright, Behind the Blue Door, (London: Bailliere Tindall, 1981), p 63.

Given that the aim of this thesis is to begin to explore the history of midwives in twentieth century Scotland, it will start by concentrating on the activities of the Central Midwives' Board, because the legislation covering midwives and their practice in Scotland differed from that in England and Wales. Also, although the two CMBs aimed for reciprocity of practice, they frequently held differing views, and it was their rules which set the formal framework for the practice of midwives. In addition the thesis will explore the perceptions of midwives practising during the period. It will focus on the extent to which the CMB, midwifery training, the changing location of births and the changing nature of midwifery practice, along with relationships of midwives with those in the medical profession shaped their identity and limited or facilitated their autonomy.

### **Sources, Methods and Plan**

The minutes and reports of the CMB over the period of its existence from 1916 to 1983 make it possible to examine the changes in the formal framework within which midwives trained and practised. These have been supplemented with research in Parliamentary papers and relevant Government reports. A series of forty-five interviews, conducted between 1997 and 2002, with midwives who practised in Scotland during the period of the CMB, provide information about the continuities and changes in practice, the extent to which they followed the formal Rules of the CMB, their relationships with other professionals, each other and women in their care. I selected them to give a wide picture of midwifery in Scotland geographically and chronologically.

The thesis focusses on female midwives. Until 1975 midwifery was one of the professions where discrimination on the grounds of gender was permitted. The 1975 Sex

Discrimination Act removed the barrier to men becoming midwives and in 1977 two pilot schemes included male student midwives in England and in Scotland. There are currently very few male midwives practising in Scotland. However their contribution to midwifery needs to be recognised. One of the interviewees was the first male Scot to undertake midwifery training in Scotland and he provided a sensitive insight into present day male midwifery.<sup>46</sup>

It turned out that three of the midwives were at one time members of the CMB and thus able to give personal insight into working with the Board. This work has focussed on the activities of the CMB through Minutes and published Reports. To have personal insight of how it was from a member's eye view was particularly useful. Due to time constraints I was not able systematically to interview other members of the CMB. However discussion with the three midwives has indicated that there is material here worthy of further investigation. The uses and limits of oral history in general and as used in this thesis are discussed in Appendix 1. The details of specific oral history interviews are recorded in Appendix 4. This thesis therefore brings together both archival research and oral history. The use of oral history makes it possible to set midwifery as practised by midwives alongside the ideals of the Rules of the CMB. The thesis is divided into two parts. Part one focusses on the development and work of the CMB from 1916 to 1983. It relies mainly on archival research with use of oral history testimony where relevant for illustration. Part two is concerned with changes in the practice of midwives over the same period. It uses oral testimonies yet refers to CMB records and other sources where necessary to give extra evidence.

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<sup>46</sup> LR, 17 [88].



Part 1 begins with an examination in Chapter 1 of the background to the Midwives Acts in Britain. It looks briefly at the development of male medical practitioners in childbirth and early attempts to formalise midwifery training in Scotland in the eighteenth century. I explore the issues surrounding a Midwives Bill for England and Wales, including opposition to the Bill, medical attitudes, both English and Scottish, and why the Bill, which eventually was passed as the 1902 Midwives Act, did not cover Scotland. The chapter also examines the campaign for, and opposition to, a similar Bill in Scotland in order to illuminate reasons why the Midwives (Scotland) Act was passed when it was. The 1915 Act provided for the setting up of a CMB in Scotland which was crucial for establishing the framework within which midwives in Scotland practised. Yet because there were significant differences between the two Midwives Acts, also discussed in chapter one, the respective CMBs published Rules which differed in form and content.

Chapter two focusses on the membership, work and activities of the CMB over the period from 1916-1921. It examines the initial Constitution and proceedings of the Board, the appointment of Committees of the Board, the making of Rules for midwives, why the CMB saw the need for very detailed Rules and the establishment of midwifery training courses and examination procedures.

Chapter three examines the work of the CMB from 1922 to 1938, a period of national concern over the MMR. The Scottish Board of Health (SBH) followed by the Department of Health for Scotland (DHS) investigated the MMR through departmental committees in the 1920s and 1930s which led to the 1927 Midwives and Maternity Homes Act and the 1937 Maternity Services (Scotland) Act. This chapter explores the

CMB's response to the concern expressed in Government reports and legislation. It endeavoured to raise standards by extending the length and raising the quality of midwifery training. Yet the decisions to extend midwifery training twice within this period caused the Board anxiety and problems with the CMB (E&W) which this chapter discusses.

Chapter four examines aspects of the CMB's work from 1939 to 1959. Two particularly far-reaching events were World War II and the National Health Service Acts, implemented in July 1948. The war brought: refugees from other countries who wanted to train as midwives in Scotland; circumstances leading to an acceleration of the trend for hospital births; and problems arising from the shortage of midwives which continued after the war. The administrative structure of the NHS changed the way midwives practised and encouraged more births in hospital. The way the Board tackled these issues are discussed along with changes in midwifery education for both midwife pupils and teachers. There were also changes in the Rules in response to changes in post-war midwifery, including midwives' administration for the first time in Scotland of inhalational analgesia.

In chapter five, I examine some of the important issues which impinged on the work of the CMB and its new Executive Committee from 1960 to 1983. A major issue was the threat to a career-structure for midwives in management and teaching. This first became noticeable as hospital management began to remove 'midwifery matrons' with consequent perceived loss of status. These changes were particularly apparent in the late 1960s and 1970s. In this chapter I shall explore changes in midwifery management and teaching and how the CMB handled the problem. This chapter also examines other issues

linked with the career structure, management and education of midwives in the 1970s and early 1980s. They included the Midwifery Directives of the European Union, the CMB's difficulty in reaching agreement with the other UK Boards over this issue, and the work and report of the Committee on Nursing which eventually changed how midwifery was governed.<sup>47</sup>

Part two focusses on the practice of midwives in Scotland during the period, with regard to antenatal, intranatal and postnatal care. These chapters use evidence from oral testimonies of midwives working within the framework established by the 1915 and subsequent relevant Acts, and by the CMB. In chapter six I examine the development of antenatal care, whether midwives were or were not involved, changes in the CMB Rules concerning antenatal care and how the coming of the NHS affected the amount of care midwives were able to give.

Chapter seven discusses intranatal care and the midwife's changing role. It also explores the work of uncertified midwives or howdies who, despite legislation, were evident in Scotland until the 1950s. The move from home to hospital as the place where most women give birth was one of the major changes in maternity care in the twentieth century. This chapter argues that medicalisation of childbirth including hospitalisation with subsequent fragmentation of care for mothers had a large part to play in the reduction of the autonomy of midwives in Scotland.

Chapter eight describes the development of postnatal care and how this aspect of midwifery became the main remit of many community midwives. It examines postnatal

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<sup>47</sup> Council Directives of 21 January, 1980: (80/154/EEC), Official Journal of the European Communities, No L 33/1, and (80/155/EEC), Official Journal of the European Communities, No L 33/8; <sup>47</sup> DHSS and SHHD Report of the Committee on Nursing, Cmnd 5115, (London: HMSO 1972).

care in Scotland by a midwife at home and in hospital, and the concept of planned early discharge home. I also discuss the possibility that when maternity care is fragmented, giving poor continuity of care for mothers, the midwife at the same time, becomes de-skilled in other areas of midwifery practice leading to a loss of her personal identity and autonomy.

The conclusion to the thesis sums up the evidence of the previous chapters and endeavours to evaluate the level of midwifery autonomy lost, gained or maintained throughout the period. It suggests directions for further research and will also give a brief glance into midwifery in Scotland after 1983.

## **Part I**

### **Regulation and the Central Midwives Board: 1916-1983**

## Chapter 1

### Midwifery in Scotland and the coming of Regulation

Commentators and historians have described midwives before the twentieth century across a spectrum from ignorant to able. At one extreme, according to Professor R W Johnstone, they were

too ignorant to recognise the signs of danger and so too late in seeking medical assistance...or too impatient and started to 'work upon' their patients by stretching the vulva with their hands to stimulate pains, pushing on the fundus and pulling upon any part of the unhappy foetus that afforded a grip to their searching fingers.<sup>1</sup>

On the other hand, Hilary Marland, while acknowledging the great variation in midwives' skills, competence and background, discounts the 'ignorant midwife' theory in Early Modern Europe as firmly as Irvine Loudon acknowledges midwives' ability in the late nineteenth century.<sup>2</sup>

Regardless of different views of the quality of care they provided, there is agreement that the status of midwives suffered in the eighteenth and nineteenth centuries because of their lack of formal training, lack of regulation and associated lack of professional solidarity. In addition, their status suffered because of the rising ascendancy of the male medical profession and the fact that midwives were predominantly women, who characteristically were 'listening, feeling [and] attached' as opposed to the more

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<sup>1</sup> R W Johnstone, 'Scotland's Contribution to the Progress of Midwifery in the Early Eighteenth and Nineteenth Centuries', *The Journal of Obstetrics and Gynaecology of the British Empire*, Vol 50, 1950, p 583.

<sup>2</sup> H Marland, ed, *The Art of Midwifery*, (London: Routledge, 1993), p 2; I Loudon, 'Midwives and the Quality of Maternal Care', in H Marland and A M Rafferty, *Midwives, Society and Childbirth*, (London: Routledge, 1997), p 186.

scientific description of the male medical practitioner: 'seeing, examining [and] detached.'<sup>3</sup>

There were efforts to formalise training and regulate midwives before the early twentieth century. But it was the legislation, first for England and Wales in 1902 and then for Scotland in 1915, which set the framework for the formal training, registration and regulation of midwives, gave them a legal basis for their professional status and shaped their relationship with doctors, nurses and patients.

### **Attempts to formalise midwifery training in Scotland**

The lack of formal training and regulation for women in midwifery were issues which medical practitioners and official bodies in Scotland attempted to address from the eighteenth century. Male medical practitioners, called originally to the birthing rooms to help in emergency situations, became a common presence even at some normal births from the mid-eighteenth century.<sup>4</sup> Concurrently, came the introduction of formal training schools for midwives and an attempt to control their activities. The first training through lectures for midwives in the United Kingdom was established in Edinburgh in 1726 when the Town Council appointed Joseph Gibson Professor of Midwifery. The Council made this appointment because it was appalled by the prevalence of what it called 'obstetrical disasters', many of which were blamed on midwives.<sup>5</sup> A similar midwifery examination and licence was established in Glasgow in December 1739 under the auspices of the Faculty of Physicians and Surgeons in Glasgow. The Faculty declared in their Act Anent

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<sup>3</sup> S Pitt, 'Midwifery and Medicine', in H Marland and A M Rafferty, Midwives, Society and Childbirth, (London: Routledge, 1997), p 220.

<sup>4</sup> J Donnison, Midwives and Medical Men, (New Barnet: Historical Publications, 1988), p 34.

<sup>5</sup> J Munro Kerr, R Johnstone, M Phillips, Historical Review of British Obstetrics and Gynaecology,

Midwives: 'That all midwives after a certain time shall pass an examination and have a licence from the Faculty before they be admitted to practise'.<sup>6</sup> The Faculty's boundaries included Lanarkshire, Renfrewshire, Ayrshire and Dunbartonshire. Its authority for framing this Act originated in an enabling Charter granted to the Faculty by James VI. In theory, the members had the power under this Act, to license midwives to practise, to try them for bad practice and to prevent them from practising further. In practice, they had difficulty maintaining the Act and the last recorded mention of a midwife's being disciplined under the Act was in 1820.<sup>7</sup>

Other midwifery lectures and examinations followed in Scotland. In Aberdeen, although there was no similar attempt to force midwives to undertake a recommended training, the Kirk Session of St Machar's Cathedral 'appalled by the ignorance of women practising midwifery' recommended that women wishing to practise as midwives should attend lectures given by an Aberdeen practitioner, Dr David Skene.<sup>8</sup> The Kirk Session also had the relevant minute from their Records reproduced in the Aberdeen Journal of 9 January, 1759 and, following the example of other Kirk Sessions, agreed to assist those 'who may not be able to afford the necessary Expence (sic) of their Education this Way' and requested voluntary contributions from members of the public who were prepared to help.<sup>9</sup>

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(Edinburgh and London: E and S Livingstone, 1954), p 348.

<sup>6</sup> D Dow, The Rottenrow: The History of the Glasgow Royal Maternity Hospital. 1834-1984 (Carnforth: The Parthenon Press, 1984), p 143.

<sup>7</sup> A Cameron, 'Licensed to Practise within their Bounds: The Faculty of Physicians and Surgeons and the Regulation of Midwives in Eighteenth Century Glasgow'. Presented at History of Nursing Research Colloquium, Oxford Brookes University, 18 March, 2000; Dow, The Rottenrow, p 143.

<sup>8</sup> G P Milne, 'The History of Midwifery in Aberdeen', G P Milne ed Aberdeen Medico-Chirurgical Society, A Bi-centennial History 1789-1989, (Aberdeen: Aberdeen University Press, 1989), p 227.

<sup>9</sup> Milne, A History of Midwifery in Aberdeen, Extract from the Aberdeen Journal, 9 January, 1759, p 239.



The local press was also used in Dundee to advertise classes in midwifery. In the Dundee Weekly Advertiser of Friday January 16, 1801 an advertisement ran:

#### MIDWIFERY

SEVERAL WOMEN having applied to Mr Grant, Surgeon in DUNDEE, for instructions in the above art, and it being inconvenient to his private practice to give the attention necessary to instruct them separately; he takes this method of acquainting them and the public, that he intends to OPEN a CLASS sometime in the month of January, 1801, for that purpose – Of the particular time and scene information may be obtained at his house in St Andrews Street, Dundee.<sup>10</sup>

Throughout Britain there was no uniformity of midwifery training and nothing to regulate it. In addition, apart from the special situation in Glasgow, any woman was able to practise midwifery and the untrained midwife was more commonly seen than otherwise, especially amongst less well-off childbearing women. As late as the end of the nineteenth century maternal and infant mortality rates remained high and this, along with a falling birth rate and resulting fear of population decline, brought maternal and child health into the political arena.<sup>11</sup>

#### **Towards a Midwives Act for England and Wales**

In the second half of the nineteenth century, occupational boundaries between midwifery and medicine continued to be contested throughout Britain. In the late 1870s members of the London Obstetrical Society proposed a Midwives Bill that would put midwives completely under their control and seriously restrict their practice.<sup>12</sup> Members of the women's movement opposed this legislation on the grounds that it placed restrictions on

<sup>10</sup> Dundee Weekly Advertiser, Vol 1, No 1, Friday January 16, 1801, p 1, reproduced in The Courier and Advertiser, (Dundee: D C Thomson and Co, Ltd), Tuesday January 16, 2001, p 6.

<sup>11</sup> I Loudon, Death in Childbirth, (Oxford: Clarendon Press, 1992), p 206.

<sup>12</sup> Donnison, Midwives and Medical Men, p 94.

women's work.<sup>13</sup> In 1881, Louisa Hubbard, a wealthy woman working for the extension of employment opportunities for women, and three midwives including Zepherina Veitch formed the new Matrons' Aid Society, later to be known as the Midwives' Institute.<sup>14</sup> Through the Society, they 'aimed to raise the status of the midwife by the recruitment of educated women and by State registration'.<sup>15</sup> Realising that to achieve their aims they required approval of leading obstetricians, they announced at the outset that the Society would work 'in harmony' with the medical profession, thus receiving co-operation in turn.<sup>16</sup> However, the price for co-operation was the exclusion of midwives from giving direct care to women whose labour was not 'normal' thus putting them into a non-competitive role.<sup>17</sup> It suited obstetricians to have this sort of co-operation with midwives. For them, the licensing of midwives was a way of establishing a lesser practitioner to relieve them of unproductive time-consuming work and a way to by-pass the general practitioners (GP).<sup>18</sup>

GPs therefore opposed legislation for the registration of midwives, and some members of the General Medical Council (GMC), particularly GPs, resisted registration for many years.<sup>19</sup> The GPs believed that registering midwives and regulating their training would increase the competition for work. However the 1893-94 Report of the Midwives' Registration Select Committee argued that with more education, more

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<sup>13</sup> Donnison, *Midwives and Medical Men*, p 95.

<sup>14</sup> B Cowell and D Wainwright, *Behind the Blue Door, The History of the Royal College of Midwives, 1881-1981*, (London: Baillière Tindall, 1981), p 18.

<sup>15</sup> Donnison, *Midwives and Medical Men*, p 111.

<sup>16</sup> *Ibid*, p 112.

<sup>17</sup> R Mander and L Reid, 'Midwifery power', R Mander and V Fleming, eds, *Failure to Progress: The Contraction of the Midwifery Profession*, (London and New York: Routledge, 2002), p 4.

<sup>18</sup> R Dingwall, A Rafferty and C Webster, *An Introduction to the Social History of Nursing*, (London: Publisher, 1988), p 154; Cowell and Wainwright, *Behind the Blue Door*, p 24; Donnison, *Midwives and Medical Men*, p 142.

<sup>19</sup> Donnison, *Midwives and Medical Men* p 138.

midwives would recognise the abnormal and call medical aid, thus theoretically ruling out the threat to medical practice if midwives were to be registered.<sup>20</sup> This reinforced the view of the British Medical Journal in 1890 which claimed that the medical profession favoured registration of midwives.<sup>21</sup>

The different parts of the medical profession were not the only groups which had to be won over. Registration was also opposed in the 1890s by some midwives particularly those of the Manchester Midwives' Society who saw registration and the projected plans of governance by a board mainly staffed by medical men as a removal of much of their autonomy.<sup>22</sup>

In addition, some members of the British Nurses' Association (BNA) opposed midwives' registration. Members of the nursing profession campaigned for registration at the same time as midwives. In an attempt to strengthen the nurses' cause, Mrs Bedford Fenwick, leading the BNA, suggested an alliance between midwives and nurses. However, members of the Midwives' Institute (the successor to the Matrons' Aid Society and fore-runner of the College of Midwives) stated that their members were independent practitioners and, as such, required 'separate and prior consideration', and declined to form an alliance with the nurses. From that point Mrs Bedford Fenwick and her followers campaigned against registration of midwives using terms like 'obsolete', 'an anachronism' and 'historical curiosity' when referring to midwives in the journal Nursing Record.<sup>23</sup>

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<sup>20</sup> B Abel-Smith, A History of the Nursing Profession (London: William Heinemann Ltd., 1960), p 77.

<sup>21</sup> Donnison, Midwives and Medical Men, p 128.

<sup>22</sup> Ibid, 140 and 154; Cowell and Wainwright, Behind the Blue Door, p 33.

<sup>23</sup> Dingwall, et al, An Introduction to the Social History of Nursing, p 156; Cowell and Wainwright, Behind the Blue Door, p 24; Donnison, Midwives and Medical Men, p 142.

Finally, after twenty years of effort the first Midwives Act was passed in 1902 and arrangements were made for the registration of midwives in England and Wales but not for Scotland and Ireland. This was a major landmark in the professionalisation of midwifery and for the mothers and infants they cared for.<sup>24</sup> Nevertheless, this legislation restricted midwives' practice through medical dominance of the CMB and by imposing Rules and allowing policies which promoted the idea that doctors should be the lead professionals in all areas of childbearing. In addition, through demanding an expensive education with terminology which was alien to many, it effectively barred many working-class midwives from achieving a career in midwifery.<sup>25</sup>

### **Midwifery in Scotland after 1902**

Prior to 1902, the maternity hospitals of the four major cities in Scotland, Edinburgh, Glasgow, Aberdeen and Dundee, working individually, granted certificates to midwives who trained there. In 1903, the medical staffs of these four main maternity hospitals set up a Scottish Examining Board for Obstetric Nurses which held quarterly oral and written examinations for pupil midwives. This attempt to regulate midwifery in Scotland by the medical profession and to keep midwives in Scotland as far as possible in line with those in England, was reasonably successful. The newly formed Central Midwives Board for England and Wales (CMB (E&W) ) formally recognised some Scottish maternity hospitals as training institutions and some Scottish midwives went to England to sit its new examination, though the CMB (E&W) had no jurisdiction over their practice in

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<sup>24</sup> Cowell and Wainwright, *Behind the Blue Door*, p 33; Loudon, *Death in Childbirth*, p 207.

<sup>25</sup> Mander and Reid, *Midwifery power*, p 4.

Scotland. Despite these initiatives, most midwives in Scotland remained without formal training during the first fifteen years of the twentieth century.<sup>26</sup>

It is difficult to estimate the number of midwives in Scotland before the 1915 Midwives (Scotland) Act. The census gives some indication of the numbers and changes. In the 1911 Census for Scotland, 313 females (no males) returned themselves as midwives, making a decrease of seventy-two on the 385 returned for 1901, and a further decrease on the 510 women who returned themselves as midwives in 1881. However, the number of women who returned themselves as sick nurses in 1881 was 2,179 increasing to 10,316 in 1911. While nurses were nearly five times as numerous in 1911 as in 1881, midwives were little more than half as numerous in 1911 as in 1881.<sup>27</sup>

It is likely that the Census underestimates the number of midwives practising in Scotland before the Midwives (Scotland) Act. When midwives enrolled after the 1915 Midwives (Scotland) Act over 2000 enrolled within the first year.<sup>28</sup> Firstly, it is possible that women who practised midwifery without a formal certificate used terms like 'howdie' or 'neighbour-woman' which they either did not put down on the census form or which were categorised differently in the Registrar General's office. Secondly, in the 1911 Census, the 313 women who described themselves as 'midwife' were unmarried or widowed.<sup>29</sup> It is likely that women who practised as uncertified midwives or howdies were married and practised midwifery on an informal basis without recording it on the census form. The CMB Roll from 1916 did not contain information about marital status;

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<sup>26</sup> Dow, The Rottenrow, p 151; H Tait, Maternity and Child Welfare, in G McLachlan, ed Improving the Common Weal: Aspects of Scottish Health Services 1900-1984, (Edinburgh: Edinburgh University Press, 1987), p 415.

<sup>27</sup> Census of Scotland 1911, Report on the Twelfth Decennial Census of Scotland, Vol 2, Occupations, London: HMSO, 1913, p lxxv; *Ibid*, lxxiii.

<sup>28</sup> See below, Chapter 2, p 67.

<sup>29</sup> Census of Scotland, 1911, p lxxii.

however, the CMB required marriage certificates where appropriate from midwives applying for enrolment suggesting that at least some of the midwives were married.<sup>30</sup>

Thirdly, there was the problem of recording women's occupations on a census form written, organised and completed by men who did not see occupations of women as of primary importance.<sup>31</sup> Also, as the 1911 Census Report suggests, the fall in the number of midwives and rise in the number of nurses might be partly accounted for by midwives describing themselves as nurses.<sup>32</sup>

### **Background to the Midwives (Scotland) Act**

The 1902 Midwives Act which provided legislation for midwives in England and Wales preceded the 1915 Midwives (Scotland) Act by thirteen years. The background for the Scottish Act coincides partly with that of the Midwives Act for England and Wales in that the debates for the latter took place at Westminster and included all members of Parliament. Despite this, the proposals for Midwives' Registration Bills under discussion in the mid-1890s were not intended to apply to Scotland.<sup>33</sup> One reason for this given in the House of Commons at the time was the different administrative structure in Scotland:

Mr Heywood Johnstone said ... with regard to Scotland there did not exist at present any machinery which they could invoke to put the Bill into operation, and a large number of provisions and Amendments would require to be introduced to make the Bill apply to Scotland.<sup>34</sup>

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<sup>30</sup> See chapter 2 p 60.

<sup>31</sup> A Coombs, 'Finding Herring Gutters' in Women's History Notebooks, Vol 8, No 1, Summer, 2001, pp 15-16.

<sup>32</sup> Census of Scotland, 1911, p lxiii.

<sup>33</sup> J Jenkinson, Scottish Medical Societies, 1731-1939 (Edinburgh:Edinburgh University Press, 1993), p 83.

<sup>34</sup> Hansard, Commons, Vol. 109, 6-24 June, 1902, cols 58-59, quoted in Jenkinson, Scottish Medical Societies, p 83.

The Rt Hon Eugene Wason (Clackmannan and Kinross) also explained to the House that ‘a joint Bill would have been difficult because of differences in the legal systems’.<sup>35</sup> In addition, Wason suggested a second reason why legislation for Scotland was not necessary: the situation at the time in Scotland was satisfactory as ‘these things are managed better in Scotland’.<sup>36</sup>

By arguing that legislation was not necessary Wason reflected the view of both the GPs and consultants in the Scottish medical profession. While parliamentary debates were going on in the 1890s, members of the Edinburgh Obstetrical Society (EOS), made up of GPs and consultants, discussed the issue fully. A majority of the members present demonstrated their opposition to registration of midwives in Scotland.<sup>37</sup> Some thought that it would be a long time before the establishment of a reasonable midwifery training, thus creating a danger of ‘launching a large number of unqualified women on the public’.<sup>38</sup> There was also the continuing fear that the registered midwife would encroach on their livelihood. Dr Berry Hart, opposed registration of midwives, because ‘it is doubtful if we can persuade the Legislature to interfere with the right of any woman to call herself midwife’.<sup>39</sup> Instead, he suggested midwifery nurses should be trained and registered. The advantage of midwifery nurses over midwives was that ‘the public would more readily understand the position of such, and that the women themselves would not be put in the false position of being considered duly competent to attend labour cases on their own responsibility’. Midwifery nurses would not work on their own responsibility

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<sup>35</sup> Dow, The Rottenrow, p 151.

<sup>36</sup> Ibid.

<sup>37</sup> Jenkinson, Scottish Medical Societies, p 83; ‘Should midwives be registered in Scotland?’ The Transactions of the Edinburgh Obstetrical Society, (EOS) Vol. 20, Session 1894-95, (Edinburgh: Oliver and Boyd, 1895), pp 167.

<sup>38</sup> Jenkinson, Scottish Medical Societies, p 83.

<sup>39</sup> ‘Should midwives be registered in Scotland?’ EOS, p 167.

but under the direction of a medical practitioner. In short, while the uncertified midwife or howdie would be there for a time, 'he would leave midwives to die a natural death'.<sup>40</sup> Sir William Turner agreed that 'it seemed as if the midwife in Scotland was rather an accident. She did not seem to be required, but undoubtedly she was required in England.'<sup>41</sup> There was a dissenting voice when Dr Thatcher, arguing the case for examined, registered midwives, said that

he considered that he was supported in his opinion by a great number of country practitioners, that midwives were absolutely essential in Scotland. In large colliery districts and large manufacturing districts the practitioner had not time to do the work, and it was very important that women expecting to have children should be properly attended to.<sup>42</sup>

In summing up, the President, Dr A H Freeland Barbour, commented that in Scotland there was no great need for the registration of midwives. However, he advised his colleagues to watch the progress of the Midwives Bill for England and Wales very closely as 'if anything was passed for England it would sooner or later cross the border'.<sup>43</sup>

Why was midwifery legislation eventually implemented in Scotland? One reason was the increasingly influential views of another section of the Scottish medical profession, the Medical Officers of Health (MOH), who argued that these things were not done better in Scotland. Members of the Society of MOHs for Scotland opposed the EOS

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<sup>40</sup> *Ibid*, p 181.

<sup>41</sup> *Ibid*, p 177.

<sup>42</sup> *Ibid*, p 180.

<sup>43</sup> *Ibid*, p 182; Twenty years after this discussion, he demonstrated a change of mind in keeping with the changed circumstances of a country at war. He was one of those, known as memorialists, who signed Memorial to the Right Honourables H M Secretary for Scotland and The Lord President of H M Privy Council pleading for 'the passing without delay of a Midwives Bill for Scotland': NAS, CMB 4/2/6, Memorial of the Medical Faculties of the Universities, the Royal Medical Corporations, and the Medical Officers of the Maternity Hospitals in Scotland, to the Right Honourable H.M. Secretary for Scotland and the Right Honourable The Lord President of H.M. Privy Council anent a Midwives Bill for Scotland, 19 August, 1915.



and campaigned vigorously in the early twentieth century for legislation for the training, registration and regulation of midwives in Scotland.<sup>44</sup> The heart of their case was that infant and maternal mortality rates in Scotland in general, but more specifically in Glasgow, were very high. Key figures in this campaign were Dr A K Chalmers, Medical Officer of Health (MOH) for Glasgow and Dr Campbell Munro, MOH for Renfrewshire, whose work with other members of the Society of MOHs for Scotland formed the basis of the first Scottish Midwives Bill.<sup>45</sup> In 1906, Chalmers, stimulated by work on infection surrounding childbirth and an investigation into the causes of infant deaths, began the practice of keeping a record of who attended births in Glasgow.<sup>46</sup> The 1907 Notification of Births Act, which required notification of births to the MOH within thirty-six hours of birth, reinforced this practice. Although not compulsory initially, the Local Authorities (LA) in Edinburgh, Glasgow, Stirling, Paisley and Renfrew adopted the Act from the outset.<sup>47</sup> The implementation of the Act highlighted the absence of a systematic record of the qualifications of midwives and further investigation revealed that 'a considerable proportion of them held no certificate of proficiency of any sort'.<sup>48</sup>

The growing acknowledgement of the poor physical stature of children of Britain, highlighted by the rejection of army recruits for the Boer War, further stimulated interest in the importance of maternal and infant welfare at the beginning of the twentieth century. In 1905, a delegation from Glasgow and Edinburgh attended the Congrès Internationale des Gouttes de Lait in Paris which resulted in the First National

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<sup>44</sup> Tait, 'Maternity and Child Welfare', in McLachlan, *Common Weal*, p 415; NAS, CMB 1-5, A K Chalmers, 'On the need for a Midwives Act in Scotland', in *The Journal Of Midwifery, A Weekly Record for Midwives and Maternity Nurses*, in *The Nursing Times*, February 21, 1914, pp 251-254.

<sup>45</sup> Chalmers, 'On the Need for a Midwives Act in Scotland', pp 251-254.

<sup>46</sup> A K Chalmers, *The Health of Glasgow, 1818-1925* (Glasgow: Corporation of Glasgow, 1930), p 259.

<sup>47</sup> T Ferguson, *Scottish Social Welfare, 1864-1914* (Edinburgh and London: E and S Livingstone Ltd, 1958), p 546.

Conference on Infant Mortality in Britain in London 1906.<sup>49</sup> Attended by influential representatives from across Britain including Chalmers, this conference was the forerunner of a permanent national body working for the Infant Welfare Movement. One of the major achievements of this pressure group was the passing of the first Notification of Births Act in 1907.

However, the group did not stop there. In 1908 a deputation of three from the Infant Welfare Movement met with the Prime Minister, Herbert Asquith. One of the three was Chalmers who pressed for a Scottish Midwives Act on the grounds that women who were attended by untrained midwives in Glasgow had a very high rate of puerperal fever. These women accounted for over half the annual births in Glasgow.<sup>50</sup> On further investigation in Glasgow in 1913, Chalmers again found that there were many more cases of mothers with puerperal fever where the mother had been attended by a midwife rather than a doctor; the rates were 3.4 per 1000 births for women attended by a doctor and 6.6 per 1000 for women attended by a midwife. Chalmers reasoned that the higher rate was beyond the midwife's control and not necessarily that the midwives were somehow deficient in knowledge or practice. As midwives charged less than doctors for their services, the women the midwives attended were usually poorer, less well nourished and less able to withstand infection than the clients of the doctors.<sup>51</sup> Nevertheless, Chalmers said that there was a definite correlation between the number of untrained midwives and the number of mothers suffering from puerperal fever.<sup>52</sup> While Chalmers removed some

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<sup>48</sup> Chalmers, Health of Glasgow, p 261.

<sup>49</sup> Tait, 'Maternity and Child Welfare', in McLachlan, Common Weal, p 415.

<sup>50</sup> A MacGregor, Public Health in Glasgow 1905-1946 (Edinburgh and London: E and S Livingstone Ltd, 1967), p 110.

<sup>51</sup> Ferguson, Scottish Social Welfare, p 509

<sup>52</sup> MacGregor, Public Health, p 110.

of the blame for maternal mortality from the shoulders of midwives, he implied that because of the high MMR, midwives' practice required regulation. Although he refused to blame midwives, Chalmers still reflected the claims of doctors to the House of Commons Select Committee on Midwifery Registration 1891-1893 who asserted that 'the untrained midwife was the cause of much unnecessary maternal and infant mortality'.<sup>53</sup>

Although persuasive at the time, Chalmers' data and views are contrary to other contemporary and recent studies which show that maternal mortality figures in Britain for the late nineteenth and early twentieth centuries were, on average, better for those mothers who were delivered by midwives than by doctors.<sup>54</sup> According to Dr W C Grigg, physician to Queen Charlotte's Lying-in Hospital, London, 'more cases of "injury and physical disaster" resulted from the imprudent use of forceps and turning [version] by medical men than from the negligence and ignorance of midwives'.<sup>55</sup> In addition, Dr W S Playfair, consultant to the General Lying-in Hospital, London, criticised doctors' incompetent use of antiseptics and accused them of being the 'principal vectors of the devastatingly infectious puerperal sepsis'.<sup>56</sup> Fourteen years after the Midwives (Scotland) Act, in both England and Scotland, the MMR figures were better for mothers who were delivered by midwives than by doctors.<sup>57</sup> Although Loudon emphasises that midwives

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<sup>53</sup> Chalmers' view was subsequently reiterated. Sir John Halliday Croom, the CMB's first Chairman, implied that non-regulation of midwives in Scotland before the 1915 Act was a significant factor in the maternal mortality rates: NAS, CMB 4/2/17, Sir John Halliday Croom, 'The Midwives (Scotland) Act: its Object and Method', the Maternity and Child Welfare Conference, Glasgow, March, 1917.

<sup>54</sup> M Tew, Safer Childbirth? A Critical History of Maternity Care, 2<sup>nd</sup> ed, (London: Chapman and Hall, 1995), p 273, 281 and 283; Loudon, Death in Childbirth, p 241, also cites a lack of improvement in MMR figures in the years 1910-1934 associated with increased [iatrogenic] interference and the 'employment of surgical measures in normal and moderately difficult labours'.

<sup>55</sup> BMJ, 1891, 1, p 230, quoted in Tew, Safer Childbirth? p 274, and Donnison, Midwives and Medical Men, p 137.

<sup>56</sup> Donnison, Midwives and Medical Men, p 138, refers to, Obstet. Soc. London, Transactions, 1885, Vol.xxvii, p 218; Tew, Safer Childbirth? p 274

<sup>57</sup> Loudon, Death in Childbirth, p 244.

should be formally trained, he has no doubt that midwives were able to provide a maternity service with a very low MMR.<sup>58</sup>

A second major reason why legislation was enacted for midwives in Scotland was that the welfare legislation of the early twentieth century provided the administrative basis said to be lacking in Scotland during the debate leading up to the 1902 Midwives Act. The Midwives (Scotland) Act was part of the Schemes of Maternity and Child Welfare. The Schemes emerged in Scotland in the early twentieth century and resulted in other related acts which laid an administrative basis for the Midwives Act.<sup>59</sup> In 1907 the Notification of Births Act, although not compulsory, led to early notification of births and from there, care and supervision of infants by an emerging system of health visiting.<sup>60</sup> In 1908 the Children Act was passed. It was designed to protect particularly disadvantaged children, by investigating infant deaths and their causes much more thoroughly than before, using the Notification of Births Act passed a year earlier. Thus, health visitors could use the knowledge that births had taken place to visit homes with infants and encourage good feeding and attendance at infant clinics. This Act preceded significant reductions in infant mortality rates.<sup>61</sup> Also in 1908 the Education (Scotland) Act provided medical inspection and treatment where needed for school children.<sup>62</sup> In 1915 the Notification of Births (Extension) Act was passed. This Act made compulsory the provisions of the 1907 Notification of Births Act and its particular timing was used by memorialists in their appeal for a Midwives (Scotland) Act:

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<sup>58</sup> Loudon, I, 'Midwives and the Quality of Maternal Care', in H Marland, and A M Rafferty, Midwives, Society and Childbirth, (London: Routledge, 1997), pp 180-200.

<sup>59</sup> W L MacKenzie, Report on the Physical Welfare of Mothers and Children, Vol 3, Scotland, (Dunfermline: The Carnegie United Kingdom Trust, 1917), chapter 49, pp 535-561.

<sup>60</sup> MacGregor, Public Health, p 111.

<sup>61</sup> Chalmers, Health of Glasgow, pp 195-204; Ferguson, Scottish Social Welfare, pp 551-553.

<sup>62</sup> MacKenzie, Mothers and Children, p 535.

In favour of taking immediate action, we would further urge the recent precedent by which the Notification of Births Act was by special legislation made applicable to the whole country in order to meet a national emergency arising out of the war conditions. This measure will fail of its full beneficial effect in Scotland unless it is supplemented by the Midwives Act for which we desire to plead.<sup>63</sup>

The Notification of Births (Extension) Act gave wide powers to Local Authorities (LA) in Scotland through the Local Government Board for Scotland (LGBS).

Any Local Authority within the meaning of the principal Act may make such arrangements as they think fit, and as may be sanctioned by the Local Government Board for Scotland, for attending to the health of expectant mothers and nursing mothers, and of children under five years of age.<sup>64</sup>

Although enabling rather than compulsory, the powers of Scottish LAs, thus extended, were put to even greater use with the passing of the Midwives (Scotland) Act in 1915. As already stated, the 1902 Midwives Act was not intended to apply to Scotland and its exclusion was vigorously defended by Heywood Johnstone and Wason because of what they said was the lack of an appropriate administrative structure and differing legal system in Scotland. Now, with LA powers in place, any objection to a Midwives Act for Scotland was invalid.

Thus, in the long term in Scotland the increasing influence of the MOHs and the welfare legislation of the first decade of the twentieth century overcame the initial opposition of GPs and consultants.

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<sup>63</sup> NAS, CMB 4/2/6, Memorial anent a Midwives Bill for Scotland, 19 August, 1915.

<sup>64</sup> 'Notification of Births (Extension Act) 1915', quoted in MacKenzie, Physical Welfare of Mothers and

### **Moving towards legislation for midwives in Scotland.**

The first Midwives (Scotland) Bills were put forward before the outbreak of World War I. There is evidence that opinion had shifted in Scotland to unanimous support and the Act might have passed sooner but for the outbreak of war. Nevertheless, the war put the Act's passage beyond doubt when its provisions were portrayed as part of the war effort. The first reading of a Midwives (Scotland) Bill took place in the House of Commons on 23 April 1912. Its purpose was 'to secure the better training of Midwives in Scotland, and to regulate their practice'.<sup>65</sup> It was drafted as a consequence of the efforts of the 'infant mortality movement' by the Society of MOHs, and in particular Dr Campbell Munro, MOH for Renfrewshire, but it fell through.<sup>66</sup>

The next Bill was put forward in April 1914. The Scottish Examining Board for Midwives set up in 1903 by the hospitals in the four Scottish cities eventually ceased to function in 1914 because of lack of Government support. Certificates given to midwives training through the hospitals were the only protection against the work of the untrained midwives or howdies, many of whom were employed by families obtaining maternity benefit under the National Insurance Act of 1911.<sup>67</sup> In February 1914, recognising the need for action, representatives from the hospitals of the four cities prepared for a privately sponsored bill promoting the legislation for midwifery in Scotland. The result was the presentation of an amended Midwives (Scotland) Bill to the House of Lords on

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Children, Volume 3, p 535; this clause was not included in the corresponding Act for England and Wales.

<sup>65</sup> Hansard, Commons, Vol 37, April 15- May 3, 1912, col 942.

<sup>66</sup> Chalmers, 'On the Need for a Midwives Act in Scotland', The Journal of Midwifery, The Nursing Times, (Feb.21, 1914), pp 252; Croom, Midwives (Scotland) Act: its Object and Method, p 1.

<sup>67</sup> Dow, The Rottenrow, p 152.

1 April, 1914. Lord Balfour of Burleigh who was 'in charge'<sup>68</sup> of the 1902 Midwives Bill for England, hinted at why the Act was not passed in Scotland at the same time:

I became aware that opinion was not sufficiently ripe in Scotland to make it expedient at that time to extend similar proposals to the country north of the Tweed. I need not go into the reasons for it. There are certain differences of practice, and opinion was not in favour of the change at that time.<sup>69</sup>

Lord Balfour emphasised the changes in attitudes in Scotland towards midwifery legislation and how in 1914, opinion in favour of a Bill was 'practically unanimous'.<sup>70</sup> This included opinions from the Committee of the British Medical Association (BMA) for Scotland, the LGBS, the Medical Service Committee for the Highlands and Islands of Scotland, the MOHs of many large towns, the medical staff of the 'four great centres of medical education – Edinburgh, Glasgow, Aberdeen and Dundee' and nurses at an 'important nursing conference in Glasgow', held the previous month.<sup>71</sup> There is no mention of any opinion from midwives. However, because of the frequent use of the term 'nurse' for 'midwife' it is possible that some of these nurses were midwives.

This Bill was held up for a long time. It might have become law that year but war broke out which turned Parliamentary attention away from it and it was 'dropped in the House of Commons mainly for want of time at the end of a busy session'.<sup>72</sup> There were also Parliamentary rules about measures Parliament could address during wartime. There was a disagreement in the Commons over a Scottish Bill taking precedence over English measures especially during wartime with the argument that the Midwives (Scotland) Bill was not directly to do with the war, However other members saw it as an emergency

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<sup>68</sup> Hansard, Lords, Vol 15, 1 April, 1914, col 877.

<sup>69</sup> Ibid.

<sup>70</sup> Ibid.

<sup>71</sup> Ibid., col 879.

<sup>72</sup> Dow, Rottenrow, p 152; NAS, CMB 4/2/6, Memorial anent a Midwives Bill for Scotland.

measure and it also had the approval of the Minister of Munitions.<sup>73</sup> The Lord President of the Council, the Marquess of Crewe, defending the Bill's passage during wartime, declared that the Bill was urgent and a war measure due to the mortality of war, the current awareness to preserve new life and the fact that war was instrumental in many doctors' being called up for military service. Their absence created a void in maternity care which was rapidly being filled by midwives, many of whom were unqualified and uncertificated.<sup>74</sup>

According to Sir John Halliday Croom, the action of influential medical personnel was the origin of the 1915 Midwives (Scotland) Act.<sup>75</sup> The Memorial anent a Midwives Bill for Scotland was sent with thirty influential signatures to the Secretary for Scotland and the Lord President of the Privy Council on 19 August, 1915.<sup>76</sup> Signatures included those of medical practitioners, obstetricians, MOHs, lecturers and examiners from Scottish universities and other university professors and deans. The urgency of the need for a Midwives Bill for Scotland was made clear at its second reading in the Commons on 25 November, 1915, by McKinnon Wood, Secretary for Scotland, who said that he had been approached by representatives from the medical profession, public health authorities and the Principal of Glasgow University making a case for a Midwives Act for Scotland, particularly at this time of war.

As the House is aware, the medical profession has been sadly depleted. A great many doctors have gone to the front, leaving rural districts inadequately provided with medical practitioners; so that competent midwives are absolutely necessary throughout Scotland .... The Scottish midwife is not able to obtain a formal qualification except in England. When she returns to Scotland she is not under the

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<sup>73</sup> Hansard, Commons, Vol 25 10 November, 1915, col 1167; Hansard, Commons, Vol 26, 1 December, 1915, col 814.

<sup>74</sup> Hansard, Lords, Vol 20, 8 December, 1915, col 569-570.

<sup>75</sup> Croom, Midwives (Scotland) Act, its Object and Method, p 1.

<sup>76</sup> NAS, CMB 4/2/6, Memorial anent a Midwives Bill for Scotland.



same control as the English midwife is. Altogether, I think, the case for treating this as a matter of urgency is virtually made out on very high authority indeed.<sup>77</sup>

The Midwives (Scotland) Bill received the Royal Assent on 23 December, 1915 and came into operation on 1 January 1916.<sup>78</sup> However the speedy enactment of the Bill was due primarily to the shortage of doctors in Scotland because of the war and not because of the need to recognise the importance of the profession of midwifery and its place in the health care of the people of Scotland.<sup>79</sup> The Bill's passage through the Houses of Parliament was helped by many of its clauses being similar to those in the Midwives Act pertaining to England and Wales, and as Wason (who had previously argued against midwifery legislation in Scotland) said, 'that measure has, I believe worked exceedingly well'.<sup>80</sup>

### **Provisions of the Midwives (Scotland) Act 1915<sup>81</sup>**

The Provisions of the Midwives (Scotland) Act were very similar to those of the Midwives Act 1902 with the exception of those differences described later. The text is divided into twenty nine sections which lay down rules regarding: certification of midwives and provision for existing midwives; the Constitution of the Central Midwives Board for Scotland, its future revision, and duties and powers of the Board; Rules pertaining to suspension of midwives, offences, expenses, return of the certificate after suspension and removal of names from the Roll; Rules about local supervision of midwives; annual reports and definitions.

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<sup>77</sup> Hansard, Commons, Vol 26, Nov 22-Dec 17 1915, col 480-481.

<sup>78</sup> Hansard, Commons, Vol 27, Dec 23 1915, col 806.

<sup>79</sup> Jenkinson, Scottish Medical Societies, p 84.

<sup>80</sup> Hansard, Commons, Vol 26, Nov 22-Dec 17, 1915, col.482.

<sup>81</sup> Acts of Parliament, 1915 Midwives (Scotland) Act, [5 & 6 Geo.5 Ch 91].

As in England and Wales, a Central Midwives Board (CMB) was set up in Scotland as an examining and supervisory body and to establish a Roll of midwives. Its duties included the regulation of the issue of certificates, conditions of admission to the Roll of midwives, the course of training in midwifery and conduct of examinations and remuneration of examiners. Also, as in England and Wales, the Scottish CMB recognized three categories of midwife to begin with:

those who were enrolled ‘by virtue of bona fide practice’ who were nicknamed the ‘*bona fides*’; the ‘certificated midwives’ who had obtained a certificate from one of a variety of institutions ... and were enrolled ‘by virtue of prior certification’; and ... those who had taken and passed the CMB examination.<sup>82</sup>

The ‘*bona fides*’ had to have been in practice for a minimum of a year before the passing of the Act and had to be of ‘good character’. Although the ‘*bona fides*’ could be registered without examination, one third of the candidates presenting themselves for the first CMB examination were already on the new CMB roll of midwives in Scotland as *bona fide* midwives and had voluntarily come forward for examination.<sup>83</sup>

After a year’s grace no woman could call herself, or even imply that she was a midwife without being certified under the Act.<sup>84</sup> Also, after 1 January 1922, another five years’ period of grace, no woman in Scotland ‘shall habitually and for gain attend women in childbirth otherwise than under the direction of a registered medical practitioner unless she be certified under this Act.’<sup>85</sup> This breathing space was similar to that which had been

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<sup>82</sup> Loudon, *Death in Childbirth*, p 208.

<sup>83</sup> Croom, *Midwives (Scotland) Act, Its Object and Method*, p 3.

<sup>84</sup> This rule was similar to Section 3 of the 1878 Dentists Act: R M Ross, *The Development of Dentistry: A Scottish Perspective Circa 1800-1921*, unpublished Ph D Thesis, the University of Glasgow, 1994.

<sup>85</sup> *Midwives (Scotland) Act, 1915*, 1,(2).

allowed in England and Wales and was seen as a reasonable time to effect the change necessary for midwives to conform to the Act.<sup>86</sup>

The use of the term, 'habitually and for gain' which appeared in both Midwives Acts was controversial.<sup>87</sup> It allowed uncertified women to practise midwifery as long as it could be seen that they were not doing it 'habitually and for gain'. This, and the phrase 'otherwise than under the direction of a registered medical practitioner' left loopholes in the law for exploitation by some uncertified midwives and some medical practitioners.<sup>88</sup> However, in his paper to the Maternity and Child Welfare Conference in Glasgow, March 1917, Sir John Halliday Croom, the first Chairman of the CMB for Scotland, said

there is one point of regret, namely, that the qualifying words 'habitually and for gain' which was a distinct flaw in the English Act, is perpetuated in the Scottish one, but we have good reason to believe that had the abolition of these words been insisted upon the Act would not have been passed.<sup>89</sup>

Under the provisions of the Act, a separate CMB for Scotland comprising twelve members was set up early in 1916. The CMB had the power to frame rules which were valid only after approval by the Privy Council who had to take into consideration comments from the GMC.<sup>90</sup> However there is nothing to say that the Privy Council had to act upon any recommendations which the GMC might have made.

To a certain extent, the Scottish CMB benefited from observation of the working of the CMB (E&W) and the introduction of certain improvements within the Scottish Act not yet acquired by the other CMB. An important difference between the two CMBs was

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<sup>86</sup> Cowell and Wainwright, Blue Door, p 43.

<sup>87</sup> Hansard, Commons, Vol 26, Nov 22-Dec 17 1915, col 482.

<sup>88</sup> Midwives (Scotland) Act, 1915, Section 1, (2).

<sup>89</sup> Croom, Midwives (Scotland) Act, Its Object and Method. Croom did not explain why he felt the Act would have not been passed if the words 'habitually and for gain' had been omitted. MPs may have felt that to do so would have made too much of a difference between the Acts for Scotland and England and Wales.

<sup>90</sup> NAS, CMB 4/1-5, A Fitzroy, Preliminary Statement to the Schedule of Rules Framed by the Central Midwives Board for Scotland (London: His Majesty's Stationery Office, 1916).

that the CMB (E&W) comprised nine members; having twelve members on the CMB for Scotland made room for the statutory inclusion of two midwives. The CMB (E&W) to begin with had no statutory midwife members, although midwives sat on the CMB (E&W) as representatives of other bodies.<sup>91</sup> Other differences were financial. Scottish LAs had authorisation to contribute towards financial costs: of training of midwives (although for many years midwives in Scotland had to pay for their training and had no income); of midwives' expenses, for example, compensation for loss of income due to suspension; of payment and supply of official forms and stamped envelopes; and payment of a doctor's fee when called out in an emergency by a midwife. This fee was recoverable from 'the husband or guardian of the patient if possible.'<sup>92</sup> These differences were eliminated with the implementation of the 1918 Midwives Act for England and Wales.<sup>93</sup> This included the Treasury's decision in 1919 to make a grant of £20 to each pupil midwife in England and Wales who guaranteed to practise on qualification.<sup>94</sup>

The Scottish CMB also had the power from its outset, to suspend midwives who broke the rules; the CMB (E&W) only had the power to take the more extreme step of striking from the Roll, midwives whose behaviour warranted this.<sup>95</sup> Another difference between the two Acts was to do with reciprocity of midwifery practice. The Midwives (Scotland) Act contained a clause enabling certified midwives from, for instance

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<sup>91</sup> Donnison, *Midwives and Medical Men*, p 177; Dingwall, Rafferty and Webster, *Social History of Nursing*, p 158; Cowell and Wainwright, *Behind the Blue Door*, p 36; The Privy Council, the Queen's Nursing Institute and the Royal British Nursing Association each nominated a member of the Midwives' Institute to the CMB (E&W) as its representative. The 1918 Midwives Act for England and Wales made statutory provision for two midwives to sit on the CMB (E&W);

The appointment of two midwives to the CMB is discussed in chapter 2 p 57.

<sup>92</sup> *Midwives (Scotland) Act*, 6 (2); *Ibid*, 22 and 7.

<sup>93</sup> J Towler, J Bramall, *Midwives in History and Society*, (London: Croom Helm, 1986), pp 185 and 203.

<sup>94</sup> Towler and Bramall, *Midwives in History and Society*, p 205.

<sup>95</sup> *Midwives (Scotland) Act*, 1915, 6; Cowell and Wainwright, *Behind the Blue Door*, p 49.

England, to be certified in Scotland.<sup>96</sup> This was not reciprocal to begin with, but was also amended with the 1918 Act after which midwives who had passed the CMB examinations in England and Wales, Scotland and Ireland, could practise in any of the countries on payment of an enrolment fee.<sup>97</sup> In 1950 the Midwives (Amendment) Act ensured further reciprocal recognition and certification of midwives between the four UK countries.<sup>98</sup> This meant that midwives could practise freely between these countries without re-enrolling.

The 1915 Midwives (Scotland) Act, like that for England and Wales, placed much of the responsibility for supervising midwives and regularising midwifery with LAs. Under the Act, each LA became the Local Supervising Authority (LSA) over midwives.<sup>99</sup> The power of LAs in Scotland was strengthened in 1915 by a clause in the 1915 Notification of Births (Extension) Act, which did not apply to England and Wales and which, as we saw above, heralded the evolution of the Maternity Services Schemes in Scotland.<sup>100</sup> However, even with their wide supervisory powers, LAs were obliged to work under the rules of the CMB. As Sir W L MacKenzie noted:

It is therefore not merely an Act for the registration and training of midwives, itself a sufficiently important purpose; but it is also an administrative Act placing on the Local Authority an obligation to see that the work of the midwives is kept on the highest professional level.<sup>101</sup>

Thus the term LSA came into being with regard to the LAs' responsibilities for the supervision of midwives. Its extensive powers included: supervision of midwives

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<sup>96</sup> Midwives (Scotland) Act, 11, (1).

<sup>97</sup> Cowell and Wainwright, Behind the Blue Door, p 50; NAS 1 /2, CMB Report, 31 March 1919, in CMB Minutes, 24 July, 1919, Appendix III, p 6.

<sup>98</sup> NBS, Supervision of Midwives in Scotland, (Edinburgh: NBS, February 1998); This was consolidated the following year with the Midwives (Scotland) Act, 1951, 14 and 15 Geo 6 Ch 54.

<sup>99</sup> Midwives (Scotland) Act, 1915, 16.

<sup>100</sup> MacKenzie, Mothers and Children, p 535. I discuss this issue further in chapter 7, p 225.

<sup>101</sup> MacKenzie, Mothers and Children, p 540.

practising within their district in accordance with the Rules framed by the CMB; investigation of charges against a midwife of malpractice, negligence or misconduct, conviction or unprofessional conduct; the power to suspend a midwife to prevent the spread of infection; and 'Power of Entry' to premises where a midwife was known to be practising and also where a woman who was not a certified midwife might be practising in contravention of the Act.<sup>102</sup> The LSA was also bound to report these activities to the CMB as they happened and also through the MOH, on an annual basis.

Midwives were required to notify their intention to practise annually to the LSA. It was the LSA's duty to make sure midwives knew about this and the new rules about certification, to supply to the CMB names of all midwives who had notified their intention to practise within the district and to keep a current copy of the roll of midwives accessible for public inspection. This enabled the public if they wanted, especially to begin with, to find out which midwives were certified.

Thus, the 1915 Midwives (Scotland) Act, implemented speedily because of the war and a shortage of doctors, was also part of a move to benefit the health of mothers and babies through the provision of a practical, educational and administrative midwifery service in Scotland.

## Conclusion

Before 1915, midwifery in Scotland was 'alegal', indicating having no existing regulations or licensing requirements.<sup>103</sup> Although there were attempts to formalise

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<sup>102</sup> Donnison, *Midwives and Medical Men*, p 180; the CMB (E&W) could also suspend a midwife to prevent the spread of infection; *Midwives (Scotland) Act*, 7.

<sup>103</sup> A term used to describe midwifery in New Brunswick before 1985. See: J Relyea, 'The Rebirth of Midwifery In Canada: an Historical Perspective', in *Midwifery*, 8, 1992, pp 139-169.

midwifery training in Scotland in Edinburgh, Glasgow, Aberdeen and Dundee in the eighteenth and nineteenth centuries, regulation of midwifery in Scotland only came in 1915, thirteen years after the 1902 Midwives Act which applied to England and Wales.

In the first decade of the twentieth century MOHs in Scotland argued strongly for a Scottish Midwives Act. Their arguments were reinforced by the developing Schemes of Maternity and Child Welfare in Scotland which were not fully effective without a Midwives Act. There was another over-riding reason for the Act's speedy passage through Parliament in the later months of 1915, and emphasised in the Memorial anent a Midwives Bill for Scotland. This was that World War I was instrumental in sending many doctors from Scotland to the front leaving mothers to be looked after by midwives, many of whom were unqualified and unsupervised.

The 1915 Midwives (Scotland) Act, implemented on 1 January 1916, provided for the constitution of a CMB in Scotland to be an examining and supervisory body and to establish a Roll of midwives. Midwives enrolled with the CMB were no longer illegal. They were legal practitioners, permitted to practise normal midwifery under the terms of the Act. Also, no-one could legally imply that she was a midwife without being enrolled by the CMB. Nevertheless, the terms of the Act dictated that the CMB and LSAs would control and supervise midwives in Scotland. There were two designated places for midwife members on the original Board of twelve members, in contrast to none at all on the CMB (E&W) and this indicated a developing level of respect for the midwifery profession, but it was a long way from self-regulation.

Although the interests of GPs, consultants and MOHs regarding maternity care differed, the real power in the sphere of maternity care in Scotland remained with the

medical profession. This was evident within the CMB and in the practice of midwifery in Scotland. Firstly, the early CMB for Scotland included six members of the medical profession, forming the largest single group: with twelve Board members in total, divided into three groups, medical, midwifery and lay, the medical group was the largest. Secondly, Scotland's medical practitioners traditionally held a wider remit in their practice than their English counterparts, giving them a greater input into maternity care. As early as the seventeenth century would-be doctors had a broad education to enable them to function as general practitioners. Graduates of the Scottish university medical schools were taught and examined in medicine, surgery *and midwifery* before it became compulsory in Britain in 1886.<sup>104</sup> And finally, the part the medical profession and particularly the MOHs played in midwifery in Scotland was strengthened in 1915 by the wide powers of the LAs in Scotland acting as LSAs over midwives, and the evolution of the Maternity Services Schemes in Scotland. Thus, the medically dominated CMB, the Maternity Services Schemes, LAs and their MOHs held the power when it came to organising maternity care.

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<sup>104</sup> J Hogarth, 'General Practice' Part II Chapter 1, in G McLachlan, *Improving the Common Weal* (Edinburgh: Edinburgh University Press, 1987), p 166; M Dupree and A Crowther, 'A Profile of the Medical Profession in the Early Twentieth Century: *The Medical Directory* as a Historical Source', in the *Bulletin of the History of Medicine*, 65, (1991), p 220, suggest that approximately 85% of practitioners in Scotland in 1911 were graduates of Scottish universities.



## Chapter 2

### **The Central Midwives' Board for Scotland: Early days, 1916-1921**

The 1915 Midwives (Scotland) Act made provision for the constitution of the Central Midwives' Board for Scotland (CMB).<sup>1</sup> It was the Board's responsibility to implement measures to fulfil the aim of the Act 'to secure the better training of Midwives in Scotland, and to regulate their practice'.<sup>2</sup> The 1915 Act and similar subsequent Acts provided the statutory framework pertaining to midwives and maternity care in Scotland until 1983 when the 1979 Nurses, Midwives, and Health Visitors Act took effect, superceding all previous Acts. The 1979 Act effectively ended the work of the CMB. In Scotland on 1 July 1983 many of the functions of the CMB for Scotland and the General Nursing Council for Scotland were taken over by the new National Board for Nursing, Midwifery and Health Visiting for Scotland (NBS).<sup>3</sup>

According to the Act, the CMB was set up as an examining and supervisory body and to establish a Roll of midwives in Scotland. It had to comply with statutory rules within the Act with regard to its constitution, duties and powers. Up until the passing of the Act, any woman in Scotland could call herself a midwife and could practise as a midwife. From 1 January 1917 no woman, unless certified under the Act, could either call herself a midwife or imply that she was certified. From 1 January 1922 no uncertified woman could practise midwifery 'habitually and for gain' unless under the direction of a registered medical practitioner. Certified midwives had to comply with Rules, framed by

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<sup>1</sup> I shall refer to the 1915 Midwives (Scotland) Act as 'the Act' and the Central Midwives' Board for Scotland as 'the CMB' or 'the Board', where appropriate.

<sup>2</sup> 1915 Midwives (Scotland) Act, [5 & 6 Geo 5 Ch. 91] 1, p 3.

<sup>3</sup> NAS, CMB, Index, p 1.

the Board, communicated to the GMC and only valid when approved by the Privy Council.<sup>4</sup> It was the Board's duty to inform midwives and LAs of the Rules and, through the system of local supervision and use of the Board's Penal Cases Committee, to try and ensure that the Rules were kept. Where this did not happen the Board could admonish, suspend or remove midwives' names from the Roll.

Training and education of midwives also came under the Board's jurisdiction. This involved the Board's approving training institutions, deciding on a suitable curriculum for student midwives, where and when midwifery examinations should be held, who should teach, lecture and examine pupil midwives and who could agree a pupil midwife's competence before sitting the CMB examination.

The Board also had to manage its finances. This included managing incoming payments from midwives when they became enrolled and examination fees from pupil midwives. The Board paid out-going expenses to Board members and examiners, the salary of the Board's secretary, and all other expenses incurred in its work. To manage its finances, the Board appointed a Finance Committee which met and reported to the Board on a monthly basis.

This chapter is particularly concerned with the Board's establishment and work from 1916 to 1921 though I shall refer to later periods where relevant. Although this is a comparatively short period compared to the total length of the Board's existence, the first five years set the basis for later periods. The early days, in particular, were the days of constituting the Board, establishing the first Rules of the Board, and learning to work with LAs, MOHs, the newly activated LSAs and Inspectors of Midwives (IOMs). In

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<sup>4</sup> NAS, CMB 4/1-5, CMB Rules framed under Section 5 (1) of the 1915 Midwives (Scotland) Act, (5 and 6 Geo V Ch 91), 17 April, 1916.

addition the Board had the large job of setting up and maintaining the Roll of Midwives, of introducing midwifery courses and examinations and of developing its credibility.

### **Establishing the Board, its changing membership and Chairs**

In order to set up the Board a meeting place had to be found and the members appointed. The Act laid down that the CMB would meet in Edinburgh.<sup>5</sup> The Board Minutes gave little explanation of what it required in the way of accommodation and of its reasons for moving premises from time to time. The first meeting of the Board took place on 18 February, 1916 in the offices of the LGBS, 125 George Street. The Board used these offices until 13 April, 1916, when it moved to 50 George Square (office of Mr Robertson, Clerk to the College of Surgeons) and until 1963 occupied premises associated with the Royal College of Surgeons (RCOS). In 1963 the Board bought premises for the first time at 24 Duke Street, Edinburgh, for £5,000 and moved in on 14 February.<sup>6</sup> From there the Board moved to premises in 24 Dublin Street which were sold just before the Board handed over to the NBS in order to facilitate the handover of its functions. Thus the Board held its last meetings within the offices of the new NBS at 22 Queen Street.<sup>7</sup>

The 1915 Midwives (Scotland) Act laid down that the CMB should consist of twelve members, 'two of whom shall be certified midwives practising in Scotland'.<sup>8</sup> The Act also stated who, or which body should appoint which Board members. Of the twelve, ten members were present at the first meeting of the CMB leaving two midwives to be

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<sup>5</sup> Midwives (Scotland) Act, 3, (3).

<sup>6</sup> CMB Report, 31 March, 1963, p 2.

<sup>7</sup> CMB Report, 31 March, 1983, p 5.

<sup>8</sup> Midwives (Scotland) Act, 3, (1).

appointed when enough midwives were certified.<sup>9</sup> The first members of the Board were to retire from office together on 1 February, 1921, five years after the implementation of the Act, and every five years thereafter. They were eligible for re-appointment but if not, any replacement should be similiarly qualified.<sup>10</sup> The Board could elect its chairman from within its members and could replace any member who resigned or died before the five years were up.

The CMB could, if it wished, apply to the Privy Council to revise its constitution and if necessary increase or diminish the powers of appointing bodies or abolish and replace an appointing body with another.<sup>11</sup> As indicated below, this happened a number of times over the period. In practice, this system seemed to work well. Appendix 2 gives details of Board members, how long they spent on the Board, who appointed them and whether their background was as a doctor, midwife or lay person. This table indicates that there was a total of 136 Board members over the period 1916-1983 and some members were only on the Board for a short time while a few remained on the Board for many years. Appendix 3 lists nine Chairmen on the Board from 1916-1983. Two Chairmen, James Haig Ferguson and R W Johnstone held office for many years: a combined total of twenty-nine of the sixty-seven years of the CMB's existence.

One of the most significant features of Appendix 2 is the increase in the number of midwives appointed to the Board over the period, and, particularly latterly, largely without a statutory change. At the outset, once it was complete in July 1916, the Board included: two midwives; six members of the medical profession comprising three obstetricians, one MOH and two medical practitioners appointed by the Scottish

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<sup>9</sup> Ibid.

<sup>10</sup> Ibid, 3, (3).

Committee of the BMA; and four 'lay' members, two of whom were 'ladies' 'acknowledged to be well informed on the conditions under which midwives and nurses worked'.<sup>12</sup> After the first five years, although the statutory Constitution of the Board remained the same, another midwife was appointed by the Scottish Board of Health (SBH) and the number of medical practitioners on the Board rose to seven, reducing the number of lay members in effect to two.<sup>13</sup> The statutory minimum number of midwives remained the same until 1936, yet the number of midwives on the Board gradually increased.

In 1936 the CMB agreed to raise its total membership to sixteen including four certified midwives practising in Scotland, a step forward for midwives although they were still a minority.<sup>14</sup> They remained officially a minority even after 1951 when the Board discussed increasing the number of midwife members to eight out of the total of sixteen.<sup>15</sup> The Chairman, Professor R W Johnstone, thought that the proposal of fifty per cent midwives on the Board was too generous. 'It seemed unnecessary, and indeed, inadvisable, to give them fifty per cent of the total seats'.<sup>16</sup> Instead, the members agreed to have seven midwives on the Board, four of whom would be directly elected by practising midwives in Scotland from 1953.<sup>17</sup> This new Constitution of the Board remained in place until 1983. In time, and especially in the 1970s, more bodies chose a

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<sup>11</sup> *Ibid*, 4, (3).

<sup>12</sup> B Cowell and D Wainwright, Behind the Blue Door, The History of the Royal College of Midwives, 1881-1981, (London: Baillière Tindall, 1981), p 49.

<sup>13</sup> The SBH was set up following the 1919 Scottish Board of Health Act and, as far as the CMB was concerned, replaced the duties of the Privy Council.

<sup>14</sup> NAS, CMB 1/5, CMB Minutes, 27 November, 1936, Vol 21, p 25.

<sup>15</sup> Ministry of Health, DHS, Ministry of Labour and National Service, Report of the Working Party on Midwives, (London: HMSO, 1949) para 300: the Working Party recommended that the CMB (E&W) and the Scottish Board should each have eight midwives.

<sup>16</sup> NAS, CMB 1/7, CMB Minutes, 4 November, 1951, p1.

<sup>17</sup> *Ibid*, 14 August, 1952, p 1.

midwife than a lay person as their representative on the Board. Thus, by 1983, even though the statutory number of midwives remained at seven, there were ten midwife and six medical members.<sup>18</sup>

The growing stature of midwives on the Board was also evident in the 1970s in the election of office bearers. For many years male obstetricians held the positions of Chairman and Deputy Chairman. Finally, in 1973 Sheelagh Bramley became the first midwife to hold the office of Deputy Chairman, and in 1977 she made the final breakthrough when she was elected Chairman with another midwife Mary M Turner as her Deputy.<sup>19</sup> Mary Turner succeeded Sheelagh Bramley as Chairman in 1978 and was the last Chairman of the CMB.

### **Initial proceedings of the CMB.**

The LGBS summoned the first meeting of the Board on 18 February 1916 with Dr Leslie MacKenzie, medical member of the LGBS, initially in the chair. The tasks were to elect a chairman, appoint a secretary and set up committees. The Board agreed that the chairman should be one of the medical members, and that he should be elected by ballot, leading first to two nominees for the post.<sup>20</sup> Sir John Halliday Croom and Dr James Haig Ferguson tied with five votes each. Each held qualifications that made him appear to Board members as eminently suitable. John Halliday Croom had been Professor of Midwifery at Edinburgh University since 1905 and was renowned for his lecturing

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<sup>18</sup> See Appendix 2.

<sup>19</sup> CMB Report, 31 March, 1973, p 1; CMB Report, 31 March, 1977, p 1.

<sup>20</sup> NAS, CMB 1/2, CMB Minutes, 18 February, 1916, Vol 1, p 7.

abilities: 'no student's course was considered complete if he had not attended Croom'.<sup>21</sup>

Halliday Sutherland, an ex-student, described him thus:

Sir John Halliday Croom... tall, slender, debonair, with a short well-trimmed beard, he lectured in a swallow-tailed, silk-faced evening coat, worn over a fancy waistcoat, and well-creased cashmere trousers. This combination of garments looked unusual, especially when he raised his hand and exclaimed, 'Mark me, gentlemen, and mark me well. Orange paste for your nails, a clean shirt every day, a flower in your buttonhole, and your fortune's made.'<sup>22</sup>

James Haig Ferguson, also of Edinburgh, was an obstetrician, lecturer at the University of Edinburgh and Examiner in Midwifery and Gynaecology.<sup>23</sup> His forté was the importance of the mother's life and health, arguing that their preservation was a 'prime duty for obstetricians'.<sup>24</sup> He also devised the eponymous mid-cavity forceps still used in obstetrics today. After the first ballot Dr Haig Ferguson left Sir John Halliday Croom to be elected unopposed with Dr Haig Ferguson as deputy. They held office for five years, with yearly re-election under the Board's Rules.<sup>25</sup> Five years later, when Sir John Halliday Croom relinquished the Chair, Dr Haig Ferguson was elected.

It was necessary also to appoint a secretary to record the proceedings of the Board and keep the annually published Roll of Midwives. David Lewis Eadie was the first secretary. The Board members considered him to be very suitable, as he held other important secretarial appointments, including Registrar to the Royal Colleges of Edinburgh and the Royal Faculty of Physicians and Surgeons, Glasgow, and Clerk to the

<sup>21</sup> J D Comrie, History of Scottish Medicine Vol 2, (London: Baillière, Tindall and Cox, 1932) p 689.

<sup>22</sup> H Sutherland, A Time to Keep, (London: Geoffrey Bles, 1934), p 81; obstetricians have probably never been the same since Halliday Croom. Orange peel ointment at 3d (old pence) per ounce is listed in Botanic Treatment of Disease, (Glasgow: The Botanic Medical Hall Ltd, 1912), p 91.

<sup>23</sup> J M Munro Kerr, J Haig Ferguson, J Young, J Hendry, A Combined Textbook of Obstetrics and Gynaecology, (Edinburgh: E and S Livingstone, 1923), frontispiece.

<sup>24</sup> A Oakley, The Captured Womb (Oxford: Basil Blackwell Publisher Ltd., 1984), p 51.

<sup>25</sup> NAS CMB 1/2, CMB Minutes, 25 February, 1916, Vol 1, p 12.

Royal College of Surgeons, Edinburgh.<sup>26</sup> Mr Eadie later embezzled funds and did not live up to the trust which the Board invested in him.

The Board decided in the first instance, to appoint two main committees, Finance and Penal Cases, to undertake appropriate duties and report to full meetings of the Board. The Board could elect further committees as and when they were required. The Board Chairman and Deputy Chairman were members *ex officio* of all committees. The Finance and Penal Cases Committees comprised seven and eight members respectively with a place reserved in each for a midwife member when available.<sup>27</sup> Finances were examined on a monthly basis with a financial statement presented to the Board every month by the Secretary. The Act also required that an annual financial statement be made up to 31 December of each year, audited and a copy sent to the Privy Council.<sup>28</sup> After considering penal cases the Penal Committee referred them to Special Board meetings which were called when necessary to hear cases formally and make judgement.

### **The election of the first midwife members of the Board**

As well as electing a Chairman and establishing committees, a primary objective of the Board was to appoint two practising midwives. The 1915 Midwives (Scotland) Act stated that these midwives should 'be first appointed when...midwives so qualified are available in number sufficient to warrant such appointment'.<sup>29</sup> While acknowledging that 'there seemed to be some doubt as to whether any such midwives within the meaning of the Act were available' the Board wished to have this problem resolved quickly and

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<sup>26</sup> *Ibid*, 18 February, 1916, p 8.

<sup>27</sup> *Ibid*, 18 February, 1916, p 11.

<sup>28</sup> *Midwives (Scotland) Act*, 13.

<sup>29</sup> *Ibid*, 3 (1).



agreed to recommend two specific names to the Lord President.<sup>30</sup> However, as a result of the Lord President's reply, the Chairman moved to rescind this recommendation.<sup>31</sup> In view of the Act's wording, the Board appeared to have been premature in recommending midwives who were not yet certified by the CMB.

The lack of midwife appointments to the Board at this time was important as it played a part in delaying the initial drawing up of the Rules of the CMB. It was necessary to frame enough Rules to begin with to regulate proceedings of the Board and get the Roll into operation. The Board agreed to go ahead with this but to delay the final drawing up of the remaining Rules for two reasons. Firstly, the Board wanted to wait for the appointment of two midwife members.<sup>32</sup> Secondly, the CMB (E&W) was preparing new Rules at the same time. In the interests of uniformity, the Board agreed to wait until the new Rules of the CMB (E&W) were available for scrutiny. However, at the same time there was pressure to initiate the midwives' Roll in Scotland. Thus, the Board compromised by deciding to submit for approval the Rules necessary for making the Board and Roll operable (Rules A, B and D), but delay the finalising of the remaining Rules until two midwives were appointed. This also would give its members time to read the proofs of the new Rules of the CMB (E&W).<sup>33</sup>

Privy Council approval of the first Rules on 19 April, 1916 enabled the CMB to move forward. To encourage midwives to apply for enrolment, the Board advertised in newspapers, informed MOHs and LSAs and requested a provisional list of midwives practising in each area. Thus, the Board was soon able to send a copy of Rules D and

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<sup>30</sup> NAS, CMB 1/2, CMB Minutes, 18 February, 1916, Vol 1, p 8.

<sup>31</sup> *Ibid.*, 9 March, 1916, p 10.

<sup>32</sup> *Ibid.*, 25 May, 1916, p 14.

<sup>33</sup> *Ibid.*, 9 March, 1916, p 11; NAS, CMB 1/2, *CMB Report*, 22 March, 1917.

forms of application for enrolment to over 1,700 women in practice.<sup>34</sup> From the initial response to this, the Lord President appointed to the Board two newly enrolled midwives, Alice Helen Turnbull, Matron of the Deaconess Hospital, Edinburgh, and Isabella Lewis Scrimgeour, Matron of Govan Cottage Hospital, Glasgow.<sup>35</sup> They attended their first meeting on 6 July, 1916. Also, by July 1916 the Rules of the CMB (E&W) were available for inspection. Thus, the Rules of the Scottish Board were finally revised, adjusted and approved by 26 August, 1916, six months after its first meeting.<sup>36</sup>

### **Duties and Powers of the Board: the Framing of Rules**

A large part of the Board's duties arose from the power to frame Rules under the 1915 Midwives (Scotland) Act and the need to uphold the Rules. The initial publication of the Rules contained Rules A, B and D, along with a Schedule of required Forms of Applications and Certificates. The revised Rules approved on 26 August 1916 were presented as Rules A,B,C,D,E,F,G and H with the Schedule.

Rules A were those 'regulating the proceedings of the Board' and dealt with the day to day running of the Board.<sup>37</sup> The Board should meet on a monthly basis unless otherwise decided, the date of each meeting to be arranged in advance at the previous meeting. Other Board meetings could be convened should the need arise.

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<sup>34</sup> NAS, CMB 4/2/9, Schedule: Central Midwives Board for Scotland. Rules framed under Section 5 (1) of the Midwives (Scotland) Act, 1915 (5 and 6 Geo V c 91), 17 April, 1916; The Rules were eventually published in sections, as Rules A, B,C,D,E,F,G and H and I shall refer to them in this way. See below for Rules and areas dealt with; NAS, CMB 1/2, CMB Minutes, 25 May, 1916, Vol 1, p 14.

<sup>35</sup> Ibid, p 16; Ibid, 28 October, 1916, p 31; both of these midwives originally enrolled with the CMB for England, Alice Turnbull in October 1905 and Isabella Scrimgeour in October 1904.

<sup>36</sup> NAS, CMB 4/2/10, Schedule, CMB for Scotland. Rules framed under Section 5 (1) of the Midwives (Scotland) Act, 1915 (5 and 6 Geo V Ch 91), 26 August, 1916.

<sup>37</sup> NAS, CMB 4/2/10, CMB Rules, p 1.

Rules B were those ‘regulating the issue of Certificates and the Conditions of Admission to the Roll of Midwives’.<sup>38</sup> To receive a certificate and have her name entered on the Roll, a candidate: had to satisfy the Board that she had reached a sufficient standard of general education; she had to submit proof of marriage where appropriate and proof that she was over twenty-one years old; and she had to present a certificate of proof of the prescribed midwifery training and one of good moral character.

Rules C were those ‘regulating the course of training, the conduct of examinations and the remuneration of examiners’.<sup>39</sup> Before admission to the examination of the CMB, a candidate required training in midwifery for a period of not less than six months with a two month exemption for proof of three years approved general nurse training. Other, lesser exemptions were available for experience of children’s or gynaecological nursing.

During training the candidate had to attend twenty labours, personally delivering each mother, look after twenty mothers and their infants for ten days following labour, and attend a course of twenty theoretical lectures given by a Registered Medical Practitioner recognised by the Board as a lecturer. When a candidate fulfilled the requirements for the CMB examination she had to notify the Board enclosing the required certificates and a fee of one guinea (£1-1/- or £1.05). The examination included normal and abnormal midwifery. The normal included anatomy and physiology, pregnancy and normal labour, the care of the mother in the puerperium and the management and feeding of infants. Included here were specifications as detailed as ‘the use of the clinical thermometer and of the catheter, and the taking of the pulse’.<sup>40</sup> Other

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<sup>38</sup> *Ibid.*, p 3.

<sup>39</sup> *Ibid.*, p 4.

<sup>40</sup> *Ibid.*, p 5; CMB Rules remained detailed until 1947. See Chapter 4 p 110 for further discussion on this issue.

specifically mentioned topics were to do with cleanliness such as antiseptics in midwifery, disinfection ‘of person, clothing and appliances’ and principles of hygiene and sanitation. Listing these items in such detail demonstrates the anxiety of members of the Board about some midwives’ lack of knowledge of basic care. A K Chalmers, the MOH for Glasgow, and, as we saw in Chapter 1, one of the key advocates of the registration of midwives in Scotland, reflected this anxiety. He observed

Many of those [midwives and handywomen] who were interviewed, [in Cowcaddens in 1906] carried whatever equipment they might require, such as syringes and catheters and such disinfectants as they deemed necessary, in the pocket of their dress, and many who had a bag, misused some of the material they carried in them ... 59 carried a Higginson’s syringe, but 22 admitted using it impartially for douching or for administering enemata, frequently for the same patient and always without any effort to disinfect the nozzle save by external rubbing. Twenty two also carried no thermometer ... one had a thermometer with whose use she was unacquainted, and some did not recognise a thermometer when shown it.<sup>41</sup>

Examples of examinable subjects in abnormal midwifery were: signs of postnatal diseases, for example, puerperal fevers, obstetric emergencies and how to deal with them until medical help should arrive, and the care of children born ‘apparently lifeless’.

Rules D were to do with enrolling women already in practice as midwives when the Act was passed.<sup>42</sup> These midwives could have certificates from CMB-approved UK institutions, and they could sit the Board’s examination if they wished.<sup>43</sup> Midwives who had been in ‘*bona fide*’ practice for a minimum of a year but without a certificate could be registered, provided they were ‘trustworthy, sober and of good moral character’.<sup>44</sup>

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<sup>41</sup> A K Chalmers, The Health of Glasgow 1818-1925, (Glasgow: Corporation of Glasgow, 1930), p 262.

<sup>42</sup> NAS, CMB 4/2/10, CMB Rules, p 6.

<sup>43</sup> *Ibid*, p 7; J Halliday Croom, The Midwives (Scotland) Act: its Object and Method. Read before the Maternity and Child Welfare Conference, Glasgow, March, 1917, p 2.

<sup>44</sup> NAS, CMB 4/2/10, CMB Rules, p 7.

They could also sit the CMB examination if they wished, thus adding to their status.<sup>45</sup> To reassure LSAs of the reasonableness of enrolling *bona fide* midwives, the Board justified this move by stating that it would have been very unfair ‘to have suddenly deprived of their livelihood a body of women who have been rendering useful service to the community’.<sup>46</sup>

Rules E which were extensive and detailed, dealt with regulating, supervising and restricting the practice of midwives. This included ‘directions to Midwives concerning their Person, Instruments, etc; their duties to Patient and Child; and their Obligations with regard to Disinfection, Medical Assistance and Notification’.<sup>47</sup> They gave precise instructions about hygiene, cleanliness and disinfection both personal: ‘the midwife must be scrupulously clean in every way... she must keep her nails short, and preserve the skin of her hands as far as possible from cracks and abrasions’; and instrumental: ‘all instruments and other appliances must be disinfected, preferably by boiling, before being brought into contact with the patient’s generative organs’. Rules E also gave overall rules for the care of the labouring and puerperal woman and her child but did not give specific Rules for a midwife to give antenatal care of a pregnant woman.<sup>48</sup>

For a midwife to know when to call medical assistance was (and is) considered of great importance. Rules E listed specific situations divided into those of pregnancy, labour, lying-in and the child, in which midwives had to call for medical assistance and gave the procedure to be followed. Midwives, after calling for medical assistance, had to

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<sup>45</sup> Croom, *The Midwives (Scotland) Act*, p 3.

<sup>46</sup> NAS, CMB 1/2, *CMB Minutes*, 28 September, 1916, Vol 1, p 28.

<sup>47</sup> NAS, CMB 4/2/10, *CMB Rules*, p 7.

<sup>48</sup> For further discussion on midwives and their place in the antenatal care of pregnant women, see chapter 6

stay with the mother. If there was any difficulty obtaining medical assistance they would not incur any legal liability by remaining on duty and doing their best.

Rules F, G and H dealt with administration. Rules F made it the duty of a LSA to suspend a midwife from practice for the purpose of preventing the spread of infection.<sup>49</sup> What Rules F did not mention to begin with, but was specified in the Act, was the power of the CMB to suspend any midwife accused of ‘disobeying rules or regulations or of other misconduct’ until a case against a midwife or her appeal had been decided.<sup>50</sup> Rules G dealt with the particulars required on a prescribed form when a midwife notified her intention to practise.<sup>51</sup>

Rules H applied to removal and restoration of names from the Roll.<sup>52</sup> The CMB could ask a LSA, or a solicitor acting on its behalf, to investigate and report on the legal conviction of a midwife or accusation of disobeying CMB Rules. The Penal Cases Committee then considered the case and reported further to the Board. The Board’s procedure with penal cases was complicated and carefully done, with time given for gathering of evidence and for notifying the accused midwife of what was happening, the date of the hearing and of her rights and requirements. If an accused midwife did not attend her hearing, the Board could proceed and decide upon the charges in her absence. It could remove the midwife’s name from the Roll and cancel her certificate, or punish by

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<sup>49</sup> NAS, CMB 4/2/10, CMB Rules, p 15; See also Chapter 8, p 277: Oral testimony. For details of the oral interviews conducted in relation to this research, see Appendix 4. LR, 35 [27].

<sup>50</sup> Midwives (Scotland) Act, 6, (1a) and 2; The CMB amended this omission in 1918, NBS, CMB Rules, 1918, p 40.

<sup>51</sup> NAS, CMB 4/2/10, CMB Rules, p 15; Midwives (Scotland) Act, 18.

<sup>52</sup> NAS, CMB 4/2/10, CMB Rules, p 16.

censure, caution or suspension. A de-certified midwife could apply for reinstatement and a new certificate for 10/- after six months.<sup>53</sup>

The CMB made very few Rule changes during its first five years. The date for review and possible amendment was extended to 31 December, 1921 which accorded with the date set by the Midwives (Scotland) Act as a cut-off point for unqualified midwives practising.<sup>54</sup> From then until 1983 the Government expected the CMB to review and update the Rules every five years. In practice, this order was waived many times due to the work involved in changing Rules, difficulties ensuring reciprocity with the CMB (E&W), the prospect of further Acts such as the 1937 Maternity Services (Scotland) Act which affected the Rules, and World War II which diverted the Board's attention to other activities.

### **The Local Supervising Authority (LSA)**

As described above in chapter 1, after the 1915 Midwives (Scotland) Act and the establishment of the CMB, LAs in their role as LSAs had to cope with new statutory responsibilities.<sup>55</sup> In an attempt to clarify what the Board expected of LAs under the Act, it circulated a memorandum to LAs and their MOs. This explained the legal duties and responsibilities of LSAs and their officers, procedures to be adopted and forms required for the purposes of the Act.<sup>56</sup> An important point in the memorandum was the association between the administration of the Act and that of the Maternal and Child

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<sup>53</sup> *Ibid*, p 18; NAS, CMB 1/3, CMB Minutes, 15 December, 1921, Vol 6, p 60; the six months rule was effective from 1 January 1922.

<sup>54</sup> Midwives (Scotland) Act, 2 (2).

<sup>55</sup> See Chapter 1 p 46 for the responsibilities of LSAs.

<sup>56</sup> NAS, CMB 1/2, CMB Minutes, 11 August, 1916, Vol 1, p 23.

Welfare Schemes under the 1915 Notification of Births (Extension) Act.<sup>57</sup> This highlighted LAs' financial responsibilities with consequent anticipated improvements in maternity care. The Midwives Act authorised LAs to contribute towards the training of midwives.<sup>58</sup> While the use of the word 'authorised' implies that LAs might have a choice in this matter, there is no doubting the CMB's hope that LAs would fulfil their obligations, help more midwives to train, thereby ensuring better care for mothers and babies. This was particularly important in 1916 when the Board expected a decline in the number of midwives as the 1915 Act took effect; at the same time there was a dearth of medical practitioners due to World War I.<sup>59</sup> The Board also encouraged LAs to help to pay for a midwife where a mother or her family were unable to do so. This was so that mothers would have skilled and prompt attention without worrying if they could not pay and also to help midwives secure a reasonable salary.<sup>60</sup>

LSAs were also involved in the Board's finances. According to the Act, fees paid by midwives for examinations and enrolment should go towards arranging examinations, certification and general expenses of the Board. If there was a negative balance at the end of the year, each LSA paid the Board its share of the balance in proportion to its population.<sup>61</sup>

The Board frequently had to remind LSAs and their MOHs of their duties. This included the MOH's annual report and details of names and addresses of midwives who had notified their intention to practise to the Board. Thus, the Board would know who was practising as a midwife and where, and the Board Secretary was able to maintain the

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<sup>57</sup> *Ibid*, 28 September, 1916, p 27.

<sup>58</sup> *Ibid*, 28 September, 1916, p 30; 1915 Midwives Scotland Act, 21.

<sup>59</sup> NAS, CMB 1/2, CMB Minutes, 28 September, 1916, Vol 1, p 30.

<sup>60</sup> *Ibid*.



Roll.<sup>62</sup> Yet LAs and their MOHs proved slow to send either lists of practising midwives or annual reports. After repeated reminders, in December 1920 the Board started sending out a routine annual circular to LSAs.<sup>63</sup> This was a more detailed document asking for much more information including: midwives' notifications of intention to practise, the percentage of births attended by midwives, the number of emergency cases to which medical practitioners were called, the number of cases of ophthalmia neonatorum, puerperal septicaemia and stillbirths notified by midwives and the relation of these numbers to the total number of births attended by midwives. The CMB's more formal approach towards LSAs and MOHs achieved results. The CMB Report for 1920-1921 gave figures representing the percentages of total births attended by midwives in 1920 based on information supplied by MOHs of LSAs and stated 'in view of the increasing degree in which the practice of midwifery is falling into the hands of midwives, a grave responsibility for the supervision of the practice of midwives devolves upon LSAs and upon the Board. This appears to be generally recognised.'<sup>64</sup> Thus, over the first five years of the Board's existence, LSAs appeared to have gradually understood and accepted their statutory duties with regard to supervision of midwives.

### **Midwives and the CMB**

One of the CMB's main duties was to establish and maintain the Roll of midwives in Scotland. The Board decided that every woman practising midwifery, whether alone or with a medical practitioner should apply to be enrolled and once the Roll was open many

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<sup>61</sup> 1915 Midwives (Scotland) Act, 13; NAS, CMB 1/2, CMB Minutes, 28 September, 1916, Vol 1, p 29.

<sup>62</sup> NAS, CMB 1/2, CMB Minutes, 22 March, 1917, Vol 2, p 8; *Ibid.*, 7 February, 1918, p 44.

<sup>63</sup> NAS, CMB 1/2, CMB Minutes, 17 October, 1918, Vol 3, p 27; NAS, CMB 1/2, CMB Minutes, 22 July, 1920, Vol 5, p 28; *Ibid.*, 20 January, 1921, p 54.

midwives applied for admission.<sup>65</sup> By 6 July, 1916 the Board had received five hundred applications and by 7 December 1916, the Roll of midwives contained 1,225 names.<sup>66</sup> This included midwives who had been practising before the Act was passed and sixty-nine midwives who had passed the first CMB examination, held on 30 October, 1916. Thus, to begin with, many more midwives who had been *bona fides* were enrolled than those with certificates. As shown in Table 2.1 this pattern changed dramatically over the first five years of the Board's existence as it became the norm for midwives in Scotland to sit the CMB examination.

**Table 2.1 Numbers of midwives enrolling with the CMB for Scotland in 1916-1921.**

Year.	By Certificate of an approved body	<i>Bona fide</i>	CMB Exam	Total
1916-17	728	1229	69	2026
1917-18	624	465	195	1284
1918-19	45	20	216	281
1919-20	36	75	328	439
1920-21	15	6	470	518

(Source: Annual Reports of the CMB for Scotland.)

The total number of midwives who enrolled in the first five years was 4,548. The number of practising midwives, elicited by the numbers of notifications of intention to practise received by the Board, was approximately 2,165.<sup>67</sup> This means that according to these figures only forty-eight per cent of enrolled midwives was practising in 1921. There are some possible explanations for this discrepancy. Firstly, LSAs were initially slow to send details of midwives who had notified their intention to practise. Secondly, it is possible that midwives did not fully understand that they had a statutory duty to notify their

<sup>64</sup> NAS, CMB 1/3, CMB Report, 27 July, 1921, p 8.

<sup>65</sup> NAS, CMB 1/2, CMB Minutes, 25 May, 1916, Vol 1, p 16.

<sup>66</sup> Ibid., 7 December, 1916, p 45.

<sup>67</sup> NAS, CMB 1/2, CMB Report, 27 July, 1921, p 6.

intention to practise. Thirdly, when midwives resigned voluntarily due to old age, ill health or inability to comply with the Rules, their names were retained on the Roll with a special mark to ensure that they were still under the supervision of the relevant LSA although not practising.<sup>68</sup> This complied with a GMC recommendation attempting to prevent women not enrolled by the CMB from practising midwifery under 'cover' of a medical practitioner.<sup>69</sup> Fourthly, some midwives enrolled but did not practise. Fifthly, some midwives had no intention of practising as a midwife but to be a certified midwife was a requirement for various appointments such as matron of a hospital.<sup>70</sup> Sixthly, the possession of the CMB certificate came to be seen as necessary for nursing career advancement.<sup>71</sup> Finally, Inspectors of Midwives had to hold the CMB certificate but did not have to practise.<sup>72</sup>

According to the Act, any woman who wanted to call herself a midwife had to be certified by 1 January 1917.<sup>73</sup> A woman with a certificate previously granted by an approved body or who had been in *bona fide* practice for a year before the Act was passed, was given two years to enrol with the CMB. After the deadline of 31 December 1917, enrolment necessitated passing the examination of the CMB, although the Board could and did accept late applications if it saw fit and used its power to allow late enrolment reasonably freely, especially if a good case, such as war service, were put

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<sup>68</sup> NAS, CMB 1/2, CMB Report, 17 October, 1918, p 4.

<sup>69</sup> There is further discussion of 'covering' of uncertified midwives by medical practitioners later in this chapter, p, 71.

<sup>70</sup> NAS, CMB 1/2, CMB Minutes, 30 September, 1920, Vol 5, p 33.

<sup>71</sup> M Uprichard, 'The Evolution of Midwifery Education', in Midwives' Chronicle, January 1987, p 4.

<sup>72</sup> NAS, CMB 1/2, CMB Minutes, 30 September, 1920, Vol 5 p 33.

<sup>73</sup> Midwives (Scotland) Act, 1 (1).

forward.<sup>74</sup> Thus, for many years after the deadline, the CMB Minutes recorded instances of midwives who had trained before the 1915 Midwives (Scotland) Act applying to be enrolled.

### **Inspectors of midwives (IOM)**

To comply with the Act, supervision of midwives was necessary.<sup>75</sup> As noted earlier in this chapter this was the responsibility of LSAs who were required to appoint appropriately qualified people to supervise midwives in their area. Supervision of midwives involved a LSA's making arrangements through an IOM for inspection: of midwives, their register of cases, clothing, equipment and premises if appropriate and how they practised. Midwives had to co-operate and 'give every reasonable facility for such an inspection'.<sup>76</sup>

There was some confusion about the appointment of IOMs. Initially, some midwives mistakenly applied to the Board for appointment as IOMs although the Act did not provide for posts of this name and their appointment was outwith the CMB's province.<sup>77</sup> The Board responded by telling applicants that IOMs were the LSAs' responsibility, by reminding LSAs of their duty in this respect and recommending that any IOMs appointed should hold the CMB certificate and 'their appointment should be

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<sup>74</sup> *Ibid*, 2; NAS, CMB 1/2, CMB Minutes, 13 December, 1917, Vol 2, p 40; NAS, CMB 1/2, CMB Minutes, 18 July, 1918, Vol 3, p 20; NAS, CMB 1/2, CMB Minutes, 22 April, 1920, Vol 5, p 15; NAS, CMB 1/2, CMB Report, 24 July, 1919, p 6.

<sup>75</sup> Midwives (Scotland) Act, 16 (1).

<sup>76</sup> *Ibid*; NAS, CMB 4/2/10, CMB Rules, 1916, E (25) p 16 describes in brief the duties of an IOM; in chapter 8 p 276, Mary McCaskill (LR,35 [27] ) comments on inspection by the IOM in the 1940s. By then the IOM was called Supervisor of Midwives (SOM).

<sup>77</sup> NAS, CMB 1/2, CMB Minutes, 25 May 1916, Vol 1, p15: the post of IOM was recognised in England and Wales. It is probable that those midwives making early application to the Board for such a post knew about this and thus pre-empted the Board's activity in this aspect.

determined from the qualifications held, tact and experience'.<sup>78</sup> However, later that year, after considering the matter more thoroughly, the CMB pointed out to LSAs that although there was no provision in the Act for IOMs, to comply with statutory supervision of midwives, IOMs should be a medical officer or a health visitor holding the certificate of the CMB for Scotland or England and Wales, and subject to the approval of the LGBS.<sup>79</sup> Some health visitors were used as IOMs in England and Wales and this is possibly why the CMB recommended that health visitors be used in Scotland also.

The decision to appoint health visitors with the CMB certificate as IOMs was not without problems and led the CMB to clarify the division of labour between midwives and health visitors. In November, 1917, Sarah Cairns, a certified midwife in Glasgow, complained to the Board 'anent the interference of health visitors with the duties of the midwife'.<sup>80</sup> A similar complaint came from the SMA.<sup>81</sup> The Board resolved the issue by writing to all LSAs in Scotland stating firmly that health visitors without the appointment of IOM had no right to interfere directly with the management of a mother and her baby until the midwife had stopped visiting. If worried, she should report to the IOM who should take action if necessary.<sup>82</sup>

The strict rules in Scotland about qualifications of IOMs may well have come about as a result of the English experience. Donnison points out that in England

in many areas... the work of inspection was left to persons without suitable qualifications. These were commonly health visitors, women generally of higher social status than midwives, but with little or no practical experience of midwifery, who in consequence were resented by midwives as ignorant and overbearing. In some areas, the duty was laid on the sanitary inspector, who came

<sup>78</sup>NAS, CMB 1/2, CMB Minutes, 6 July, 1916, Vol 1, p 18.

<sup>79</sup>Midwives (Scotland) Act, 16, (1); NAS, CMB 1/2, CMB Minutes, 28 September, 1916, Vol 1, p 28.

<sup>80</sup>NAS, CMB 1/2, CMB Minutes, 11 November, 1917, Vol 2, p 32.

<sup>81</sup>Ibid, 13 December, 1917, p 39.

<sup>82</sup>Ibid, 2 February, 1918, p 45.

to it 'straight from rubbish tips and drains', in others, on the poorly remunerated Medical Officer of Health himself, 'who had forgotten most of the midwifery he had ever learnt'.<sup>83</sup>

Nevertheless, for the CMB to state that an IOM should be a medical officer or a health visitor albeit with the CMB certificate indicates a hierarchy implying seniority of health visitors over midwives which lasted for many years.

### **'Covering' of howdies by medical practitioners**

For many years after the 1902 Midwives Act for England and Wales, there was a problem with uncertified women practising midwifery by themselves with the help of qualified medical practitioners who pretended to give them medical supervision. This was known as 'covering' of howdies or uncertified midwives by medical practitioners and could result in a medical practitioner's name being removed from the Register of the GMC.<sup>84</sup> After the 1915 Midwives (Scotland) Act was passed, the GMC, indicating how seriously it took this activity and emphasising that it was unacceptable, asked the CMB to issue warnings about 'covering' to medical practitioners.<sup>85</sup> In addition to being against the law, the certified midwife's livelihood was threatened by such a practice, while those in competition with her, the medical practitioner and the howdie, could prosper.<sup>86</sup>

In the CMB's first five years there is no evidence of complaints against collusion between medical practitioners and uncertified midwives as there appeared to be in England at that time. However, during this first five years, midwifery practice by the uncertified midwife in Scotland was not illegal as long as she did not call herself a

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<sup>83</sup> Donnison, *Midwives and Medical Men*, p 180; Towler and Bramall make the same point: J Towler, and J Bramall, *Midwives in History and Society*, (London: Croom Helm, 1986), p 228.

<sup>84</sup> NAS, CMB 1/2, *CMB Minutes*, 28 September, 1916, Vol 1, p 28.

<sup>85</sup> *Ibid*, 8 February, 1917, p 46; NAS, CMB 1/2, *CMB Minutes*, 19 July, 1917, Vol 2, p 23.

midwife or imply that she was certified.<sup>87</sup> It only became illegal if she practised ‘habitually and for gain’ after 1 January, 1922.<sup>88</sup> While the warnings of the GMC were timely and appropriate in England, in Scotland no doctor could have been disciplined for ‘covering’ a howdie before that date. However, the warnings drew the potential problem to the attention of the Board, the LSAs and, through MOHs, to many medical practitioners. In December 1921 the Board reminded LSAs of the law and requested MOHs to notify Procurators Fiscal of any cases which arose in their areas with a view to summary action being taken against women practising without certification.<sup>89</sup> Therefore, as well as issuing the warning again to medical practitioners about covering howdies, the Board also asked doctors to inform against them and this began to happen in 1922.<sup>90</sup> Howdies could disobey the law with the help of qualified medical practitioners, by the practitioner paying perfunctory visits to confinement cases, signing certificates or other documents under the National Health Insurance or Notification of Births Acts, and pretending that the howdie was acting under medical supervision. The first case noted in the CMB Minutes of someone using the ‘cover’ of a doctor was in 1923. Here a ‘handywoman’ was prosecuted in Kilmarnock by the Procurator Fiscal for practising without enrolment, ‘covered’ by medical practitioners certifying for maternity benefit under the Insurance Act.<sup>91</sup> She was fined £5 or twenty-one days imprisonment.<sup>92</sup> In this instance it was only the midwife who was punished. However, even with the threats of

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<sup>86</sup> Donnison, *Midwives and Medical Men*, p 181.

<sup>87</sup> *Midwives (Scotland) Act*, 1, (1) and (2).

<sup>88</sup> *Midwives (Scotland) Act*, 1, (2).

<sup>89</sup> NAS, CMB 1/2, *CMB Minutes*, 19 January, 1922, Vol 6, p 60.

<sup>90</sup> NAS CMB, 1/2, *CMB Report*, 11 May, 1922, p 5.

<sup>91</sup> NAS, CMB 1/2, *CMB Minutes*, 28 September, 1916, Vol 1, p 28.

<sup>92</sup> NAS, CMB 1/3, *CMB Minutes*, 21 June, 1923, Vol 7, p 24.

prosecution, the practice of the uncertified midwife or howdie was to continue for a long time in Scotland.<sup>93</sup>

### Medical Aid

According to the 1915 Midwives (Scotland) Act, a midwife had to summon medical aid in an emergency and a LSA had to pay his fee.<sup>94</sup> The Board informed LSAs of their duties under the Act concerning 'Medical Assistance in Case of Emergency' and made clear what it expected of midwife and medical practitioner. The midwife had to inform the LSA that she had called for medical aid, and why, and give the name of the medical practitioner. He also had to report the nature of the call-out and tender his account for fees and mileage to the LSA. The fee was fixed at £1-1/- (one guinea, £ 1.05) for consultation, to cover one subsequent visit if required, with mileage at the rate of 1/- (5 pence) per mile.<sup>95</sup> In accordance with the Act, the LSA was entitled to try and recover the debt from the mother or her family.<sup>96</sup>

It soon became apparent that some midwives had problems obtaining medical aid in an emergency.<sup>97</sup> This was an issue which, strictly speaking, was outwith the Board's control and yet had a direct bearing on the work of midwives. In England and Wales the same problem existed, exacerbated by the fact that under the rules of the CMB (E&W) the midwife had to call in a doctor in an emergency, but there was no statutory provision for his payment.<sup>98</sup>

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<sup>93</sup> See Chapter 7, p 229.

<sup>94</sup> 1915 Midwives (Scotland) Act, 22, (1).

<sup>95</sup> NAS, CMB 1/2, CMB Minutes, 28 September, 1916, Vol 1, p 30.

<sup>96</sup> Ibid, p 27.

<sup>97</sup> Ibid, 8 February, 1917, p 47.

<sup>98</sup> Donnison, Midwives and Medical Men, p 182; This led to increasingly poor relationships between doctors and midwives there. The problem of doctors' payment in England was resolved, on paper at least,



Although the Board worked with the LGBS and LSAs on the scale of fees and mileage rates LSAs should pay to medical practitioners in midwifery emergencies, there remained a widespread lack of understanding on the subject of payment and its administration.<sup>99</sup> It was not the CMB's responsibility, yet the CMB continued to receive complaints and questions until 1919 when the the Secretary to the Board started referring these to the LGBS whose responsibility it was and subsequently to the new Scottish Board of Health (SBH).<sup>100</sup> The arguments over emergency fees reflected the apprehension among many medical practitioners over the possible extension of medical benefits to cover more of the population and medical services in Scotland. Some doctors worried that this would give LAs control of medical benefit or lead to a bureaucratically controlled State medical service.<sup>101</sup>

### **Responsibility for Training Midwives**

An important part of the Board's duties included 'regulating the course of training [for pupil midwives]'.<sup>102</sup> This included both inspecting and approving potential and existing training schools or institutions, and monitoring examinations.

After the 1902 Midwives Act some Scottish training institutions were on the approved training list for the CMB (E&W). This stopped in 1917 and they were approved by the new Scottish CMB after applying for recognition along with others not specified in

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when the 1918 Midwives Act brought the legislation for England and Wales into line with that of Scotland regarding the statutory obligation for LSAs to pay for medical aid in a midwifery emergency.

<sup>99</sup> NAS, CMB 1/2, CMB Minutes, 19 July, 1917, Vol 2, p 22.

<sup>100</sup> NAS, CMB 1/2, CMB Minutes, 24 July, 1919, Vol 4, p 14; The SBH was established in 1919 'to develop wider and more co-ordinated health services for the people of Scotland; J Hogarth, 'General Practice', in G McLachlan, Ed, Improving the Common Weal. Aspects of Scottish Health Services, 1900-1984 (Edinburgh: Edinburgh University Press, 1987), p 177.

<sup>101</sup> J Hogarth, 'General Practice', p 178.

<sup>102</sup> Midwives (Scotland) Act, 5 (c).

the Act.<sup>103</sup> Thus there were teaching requirements and physical conditions to be considered before approval. The Board approved teachers of pupil midwives and this will be discussed in Chapter 4. For the Board to approve an institution, it had to examine the number of pupil midwives it trained per year, the number of cases for the previous three years both indoor and outdoor, and the number of maternity beds.<sup>104</sup>

In addition the Board made detailed requirements:

1. Women without prior nursing training and who therefore required six months midwifery training, instruction should be given in an Institution with requisite number of beds as approved by the Board.
2. That is a minimum of five beds, not less than sixty indoor cases per annum and satisfactory (to the Board) arrangements for clinical instruction. Outdoor cases should number at least 260 per annum. There should be no more than twelve pupil midwives per annum. The Medical Practitioner should be approved by the Board. The Matron should be a Certified Midwife approved by the Board to sign certificates and have two Certified Midwives as Assistants.
3. For all pupils whether they had been nurses before or not, outdoor cases day or night must have personal supervision of a registered medical practitioner or a certified midwife, approved by the Board and instruction must be given at each case to the pupil.<sup>105</sup>

CMB members inspected and reported to the Board on those institutions applying for recognition by the CMB as training schools for midwives. To some, for instance the main maternity hospitals in Edinburgh, Glasgow, Aberdeen and Dundee, the CMB gave unconditional approval. Others, for example, The Hospice, 219 High Street, Edinburgh, received recognition from the CMB for the duration of World War I. Recognition after that would depend on improvements to the premises being made.<sup>106</sup> Other institutions

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<sup>103</sup> NAS, CMB 1/2, CMB Report, 22 March, 1917, p 3; Midwives (Scotland) Act, Section 2; training institutions previously approved by the CMB for England and Wales were subsequently approved by the CMB.

<sup>104</sup> NAS, CMB 1/2, CMB Minutes, 25 May, 1916, Vol 1, p 15.

<sup>105</sup> Ibid.

<sup>106</sup> Ibid., 9 November, 1916, p 38.

applying to the Board for approval, did not receive it. The following is an example of a report of an inspection where the CMB did not accede to the application for recognition.

Scotia Street Nursing Home, Glasgow.<sup>107</sup>

This Institution seems to have a door all to itself with its name in gilt letters on the glass panel. Investigation, however, revealed the fact that this Nursing Home adjoined the consulting-rooms of Dr MacPhee, and that the one dwelling-house led into the other by an internal passage.

We found three beds were set aside for patients. One patient was stated to be in the house at the time of our visit, but the patient was out when we called.

Labours are conducted in a bathroom in which a bed is put. We particularly inquired of the nurse who showed us over the premises if this was the case, and we were assured that this was so. We made an endeavour to see this labour room, but somebody appeared to be in it.

The nurses in the Institution sleep five in a room in single beds.

The Lecture Room was the Doctor's waiting room for his private patients.

There was no responsible Matron in Charge. Her duties appeared to be discharged alternately by two of the nurses.

Absence of a proper cleaning staff had obvious effects unnecessary to describe.

The Board also made a difference between applications from larger and smaller training schools.<sup>108</sup> A recognised training institution was not necessarily subject to annual application for renewal although the Board proposed that smaller training schools, their teachers and lecturers should be approved annually.

Along with inspection and approval of training schools and institutions and their staffs, the CMB had to organise examinations for midwives. The Board's Examination Committee, first appointed in May 1916, initially comprised medical members of the Board, with a remit to make arrangements for examinations, examination questions, advertising of examinations and for examiners, and scrutiny of applications.<sup>109</sup> The plan was to hold Board examinations in Edinburgh, Glasgow, Dundee, Aberdeen and

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<sup>107</sup> *Ibid.*, p 39.

<sup>108</sup> *Ibid.*, p 34.

<sup>109</sup> *Ibid.*, 25 May, 1916, p 18.

Inverness simultaneously and, for the years 1916 and 1917, half-yearly in April and October.<sup>110</sup> Each two-hour paper consisted of four questions chosen from a selection sent to the Board by examiners, followed by a fifteen minute oral examination. The first CMB examination was held on 30 October 1916 with a total of seventy-seven candidates. Of these, Edinburgh presented one, Glasgow seventy-one, Aberdeen three and Dundee two. The Board recorded sixty-three passes with pass-marks ranging from eighty-five per cent (two candidates) to fifty per cent (nine candidates).<sup>111</sup> In the next examination, held on 30 April, 1917, also in these four cities, with Glasgow presenting the greatest number, 117 candidates entered of whom 101 passed.<sup>112</sup>

After the first examination, the committee made changes to make it more practical<sup>113</sup> with further modifications in 1921 when the Board extended the length of the written examination to three hours from 10.30am – 1.30pm with an oral and practical examination in the afternoon of the same day. With the exception of Glasgow, where the examination lasted two days, the examiners scrutinised the written papers between the morning and afternoon examinations and notified the candidates of the results on the same day.<sup>114</sup> Molly Muir who was a pupil midwife in Edinburgh in 1934 recalled, ‘I trained in the old Simpson in 1934 from June until December and we sat our exam in the Royal College of Surgeons in the following February... We had our written and our oral and on the same day we got our result.’<sup>115</sup> The seemingly impossible task for the examiners, of scrutinising papers which had been written that day, conducting oral and

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<sup>110</sup> *Ibid.*, p 19; the CMB dropped Inverness from the list due to lack of candidates.

<sup>111</sup> NAS, CMB 1/2, *CMB Minutes*, 9 November, 1916, Vol 1, p 41. All the candidates who failed came from Glasgow.

<sup>112</sup> NAS, CMB 1/2, *CMB Minutes*, 25 May 1917, Vol 2, p 18.

<sup>113</sup> NAS, CMB 1/2, *CMB Minutes*, 9 November, 1916, Vol 1, p 34.

<sup>114</sup> NAS, CMB 1/3, *CMB Minutes*, 1 June, 1921, Vol 6, p 26.

<sup>115</sup> LR, 13 [46].

practical examinations and giving the candidates their result on the same day carried on until 1939.<sup>116</sup>

### **Conclusion.**

This chapter has investigated, mainly through its Minutes and annual reports, the first five years of the CMB for Scotland. This represented its first official period of office under the chairmanship of Sir John Halliday Croom whose leadership the Board approved, recording at the last meeting of the quinquennium, its appreciation of his 'wide professional experience, freely placed at the disposal of the Board'.<sup>117</sup>

A major issue at the outset, and one of the main differences from the CMB (E&W) was the statutory requirement that two midwives should be members of the Board. The midwives could not be on the Board before they were enrolled and yet this requirement was a *sine qua non* for the finalising of the Rules. Thus, the Board had to agree on a compromise to begin with, agreeing enough Rules to get the Roll underway and therefore have the two midwives on the Board before finalising the rest of the Rules. From the relatively small number of midwives on the Board at the outset the number of midwives on the Board increased over the period from 1916 to 1983, especially during the latter years of the Board's existence. Also, over the period there were only nine Chairmen and every Chairman was an obstetrician until 1977 when Sheelagh Bramley became the first midwife Chairman.

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<sup>116</sup> For change in the examination system in 1939, see chapter 4 p 110.

<sup>117</sup> NAS, CMB 1/2, CMB Minutes, 20 January, 1921, Vol 5, p 53.

By the end of its first five years the CMB had developed from a new body, to a more confident group, prepared to take a stand.<sup>118</sup> This can be seen, for example, when the Board had difficulty at first persuading the LAs and MOHs to fulfil their statutory obligations; eventually the Board insisted on compliance with the Act and became more formal in its proceedings. By 1921 LSAs appeared to recognise the level of their responsibilities regarding supervision of midwives.<sup>119</sup>

Other bodies, such as the LGBS and the SBH appeared to be ready to consult the Board for its views and to listen to what it had to say. Sometimes, issues were outside the Board's province but impinged on the work of the Board, for example, the paying of medical fees in an emergency. An important issue within the Board's remit in this period was the complaint about a health visitor who was not an IOM interfering with a midwife's work. The Board made the position on this issue very clear to all involved.

The presence of the CMB, the Rules surrounding training and examining of midwives and the raising of standards of midwives resulted in an increasing resort to the services of certified midwives in most parts of Scotland by the end of its first five years.

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<sup>118</sup> *Ibid*, 30 September, 1920, p 31.

<sup>119</sup> NAS, CMB 1/3, *CMB Report*, 27 July, 1921, p 32.

## Chapter 3

### **The issue of maternal mortality 1922-1938**

This chapter will explain briefly the problem of maternal mortality in Scotland and the response of the Government and the CMB. The period from 1922 to 1938 was a time when the Maternal Mortality Rate (MMR) remained a cause for national concern and only began to fall in the late 1930s.<sup>1</sup> The CMB responded to this concern expressed in Government Reports and legislation by endeavouring to raise midwifery standards, to improve the education of midwives and to recruit and retain midwives of optimum quality.

In order to reduce the MMR the SBH appointed a departmental committee to conduct an investigation into Puerperal Morbidity and Mortality which reported in 1924. A similar committee (Douglas and McKinley) commissioned by the DHS reported in 1935 and made far-reaching recommendations which, as far as maternity care and the MMR were concerned, were echoed in 1936 when the Cathcart Committee reported on its investigation into the serious overall health problems in Scotland. The Reports led to Parliamentary Bills resulting in the 1927 Midwives and Maternity Homes (Scotland) Act and the 1937 Maternity Services (Scotland) Act.

The CMB responded by reviewing and changing midwives' training and examinations with the long term objective of raising standards of midwifery practice and lowering the MMR.

## Maternal mortality: the problem

There was a consensus from the early 1920s that maternal mortality in England and Wales, and Scotland was rising and that many maternal deaths were avoidable. This consensus was based on estimates of the extent of maternal mortality and on cross-national comparisons. Both of these estimates were fraught with problems including changes in rules of registration, differences in registration in different countries, the classification of a maternal death, what should be classified as an 'associated death' and multiple causes of death.<sup>2</sup> To compound the difficulties, different countries had varying methods of recording statistics and therefore accurate international comparisons were difficult to achieve.<sup>3</sup> There was also the problem of estimating the numbers of 'hidden maternal deaths'. For example, a doctor could certify a death caused by puerperal fever or post-partum haemorrhage as being caused by 'fever' or 'haemorrhage' respectively, thus masking the real cause of death. Anything which could damage a late nineteenth century doctor's name and reputation was to be avoided if possible and 'no doctor reported a death as due to sepsis if he could attribute it to another cause'.<sup>4</sup> The issues of inaccuracies encountered with statistical compilation and uniformity of statistics

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<sup>1</sup> See Glossary for definition of MMR.

<sup>2</sup> Loudon, I, Death in Childbirth, (Oxford: Clarendon Press, 1992), p 6; Womersley, J, 'The Evolution of Health Information Services', in G McLachlan, Improving the Common Weal: Aspects of Scottish Health Services, 1900-1984, (Edinburgh: Edinburgh University Press, 1987), p 553; G Bisset-Smith, Vital Registration, 2<sup>nd</sup> edition, (Edinburgh: William Green and Sons, Law Publishers, 1907), p 5. Civil registration of births, deaths and marriages was introduced in England in 1837 but was permissive rather than compulsory; Loudon, Death in Childbirth, pp 23, 25, 28.

<sup>3</sup> Loudon, Death in Childbirth, p 34.

<sup>4</sup> Ibid, p 38; Puerperal sepsis and puerperal fever (the legal term) appear to be interchangeable. Puerperal fever was made compulsorily notifiable in Britain by the 1889 Infectious Disease (Notification) Act. Later, puerperal pyrexia was made a separate, notifiable condition in Scotland. See M Myles, A Textbook for Midwives, 7<sup>th</sup> ed, (Edinburgh and London: Churchill Livingstone, 1971), p 478; Also, L Mackenzie, 'Notification of Puerperal Fever, II', The Transactions of the Edinburgh Obstetrical Society, Session LXXXVII, 1927-28, pp 38-44. (Reproduced in The Edinburgh Medical Journal, New Series, Vol. XXXV, No.3, March 1928).



internationally were also highlighted in the Report of the Salvesen Committee in 1924.<sup>5</sup> Although these statistical problems would not invalidate year by year comparisons for the same area, they might invalidate inter-area and international comparisons.

Thus, those gathering statistics had to estimate and allow for inaccuracies. Nevertheless, in the years between 1918 and 1932, there was general agreement that the MMR, was rising.<sup>6</sup> Dr Janet Campbell, reporting to the Government on maternal mortality in 1924 considered many of the deaths to be avoidable. A Scottish Departmental Committee (the Salvesen Committee) reporting in the same year came to the same conclusion.<sup>7</sup>

### **Report of the Departmental Committee on Puerperal Morbidity and Mortality**

In 1923 the SBH appointed a committee under the chairmanship of Lord Salvesen (the Salvesen Committee) to inquire into the incidence of puerperal morbidity and mortality in Scotland, to identify the causes and to suggest any remedial measures. The Salvesen Committee asked the CMB for comments but, for some unexplained reason the Board felt unable to co-operate fully.<sup>8</sup> In contrast, the SMA, in its response to the Salvesen Committee, demonstrated its concern about unqualified midwifery practice and gave three suggestions for amendments to the 1915 Midwives (Scotland) Act. These included the abolition of the controversial phrase 'habitually and for gain' which the Salveson Report subsequently included in its recommendations.<sup>9</sup>

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<sup>5</sup> Departmental Committee of the SBH, Report on Puerperal Morbidity and Mortality, the Salvesen Report, (Edinburgh: HMSO, 1924), p 4.

<sup>6</sup> A Oakley, The Captured Womb (Oxford: Basil Blackwell Publisher Ltd, 1984), p 62.

<sup>7</sup> Ibid, p 65.

<sup>8</sup> NAS, CMB 1/3, CMB Minutes, 30 August, 1923, Vol 8, p 32.

<sup>9</sup> Salvesen Report, pp 19, 9, 37.

The Salvesen Committee published its Report in 1924. It estimated the MMR in Scotland in 1922 as 6.6 per 1000 births, an increase on the mean rate of 6.2 for the years 1915-1922.<sup>10</sup> The Report, emphasising that the MMR in Scotland was reducible, made fifteen main recommendations towards this aim.<sup>11</sup> While not wishing to underestimate the importance of the poor Scottish MMR figures, the 1924 Report pointed out that they were similar to those in England after taking account of different methods of compiling statistics.

The puerperal mortality rate [in England] in 1918 is shown as 3.0 as against 7.0 in Scotland; but in England special tables are compiled showing deaths associated with pregnancy or the puerperium which have not been included in the computation. These include the deaths of puerperal women from influenza which prior to 1921 were shown in Scotland as puerperal mortality. If these further deaths are added for 1918 to the puerperal mortality, the English rate becomes 7.6; and the comparable figures for England and Scotland thus show no significant difference.<sup>12</sup>

The Salvesen Report recommended improved antenatal care, and condemned uncertified midwives. The Report attacked the practices of howdies and acquiescence from some medical practitioners who 'covered' for them, saying their lack of aseptic techniques and other dangerous midwifery practices resulted in risk for both mother and baby. In addition, the livelihood of certified midwives suffered from competition from howdies whose fees were lower and who did housework as well as midwifery.<sup>13</sup> The Report also recommended that LAs should investigate and report to the SBH every death occurring within four weeks of pregnancy.<sup>14</sup> Thus, wider information leading to greater knowledge would lead to the ultimate objective of a significantly lower MMR.

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<sup>10</sup> *Ibid.* p 5.

<sup>11</sup> *Ibid.* p 8.

<sup>12</sup> *Ibid.* p 6.

<sup>13</sup> *Ibid.* pp 19, 21.

<sup>14</sup> *Ibid.* p 31.

The implicit assumption within the Report was that the quality of midwives and midwifery care related to the MMR. This reinforces Loudon's comments on international MMR comparisons: that countries with a lower MMR had well organised midwifery education.<sup>15</sup> However, Loudon also cited English and Scottish MMR statistics which were better for midwives than for doctors and noted the improvement in the intrapartum standard of care provided by midwives, particularly in the 1930s.<sup>16</sup> Responding to the Report, the CMB pointed out to the SBH that it had taken recent steps to improve the standard of aspirant pupil midwives and the midwifery training course. The new course included extra lectures and the need for pupil midwives to witness ten births before starting to deliver babies personally. However, the CMB's main emphasis rested with the inclusion in the course of the hitherto low profile antenatal care and the hope that this would have a beneficial effect in lowering the MMR.<sup>17</sup> Also in its response to the Salvesen Report, the CMB agreed with the recommendation to amend the 1915 Midwives (Scotland) Act with a view to eradicating unqualified midwifery practice.<sup>18</sup>

### **1927 Midwives and Maternity Homes (Scotland) Act**

In the five years (1925-1929) after the Salvesen Committee's Report the MMR in Scotland continued to cause anxiety.<sup>19</sup> It remained at a minimum of 6.2 per 1000 live births reaching a peak of 7.0 in 1928.<sup>20</sup>

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<sup>15</sup> See Introduction, p 10.

<sup>16</sup> See this chapter, p 91; Loudon, *Death in Childbirth*, p 251.

<sup>17</sup> See this chapter, p 97; NAS, CMB 1/3, *CMB Minutes*, 26 June, 1924, Vol 9, p 26; although antenatal care was increasingly prominent in the midwifery curriculum, in practice, midwives found that their role in this field was small. See chapter 6, Antenatal care.

<sup>18</sup> NAS, CMB 1/3, *CMB Minutes*, 26 June, 1924, Vol 9, pp 25 and 28.

<sup>19</sup> NAS, CMB 1/3, *CMB Minutes*, 1 February, 1923, Vol 7, p 54.

<sup>20</sup> J M Munro Kerr, *Maternal Mortality and Morbidity, A Study of their Problems*, (Edinburgh: E&S Livingstone, 1933), p 59.

The SBH began work on a Bill for Scotland to address maternal mortality in Scotland from two sides. Firstly, it agreed to the Salvesen Report's recommendation for an amendment to the Act to abolish uncertified midwives. Secondly, the requirement for more hospital maternity beds in Scotland increased in the 1920s. With the stigma of poverty surrounding hospital births disappearing, more women chose this option and, from a medical aspect, more women were admitted for obstetric procedures. Amongst the new maternity beds were those within privately run maternity homes which at the time were unregistered, of 'uncertain standards' and sometimes resorted to varying strategies to bend the rules.<sup>21</sup> More legislation than that offered by the 1915 Act was needed to regulate Maternity Homes and thus, amendments to the 1915 Midwives (Scotland) Act and legislation covering maternity homes were to join within the 1927 Midwives and Maternity Homes (Scotland) Act.<sup>22</sup>

The CMB's intervention assisted the Bill's passage through Parliament. The Board was involved with the first draft in 1925.<sup>23</sup> When the Government passed the equivalent Act for England and Wales in 1926, the Board reminded the SBH of the urgent need for further legislation in Scotland,<sup>24</sup> recommended a similar Act, appropriately adjusted for Scotland, and to maintain a high profile for this issue, made sure that the recommendation was included in the annual report.<sup>25</sup> Soon, the SBH and the CMB, working together, put together a final draft of the Bill.<sup>26</sup>

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<sup>21</sup> J Kinnaid, 'The Hospitals', in G McLachlan, ed, Improving the Common Weal, Aspects of Scottish Health Services, 1900-1984, (Edinburgh: Edinburgh University Press, 1987), p 234; NAS, CMB 1/3, CMB Minutes, 2 February, 1925, Vol 9, p 50.

<sup>22</sup> NAS, CMB 2/10-14, CMB Report, 31 March, 1926, p 6; 1927 Midwives and Maternity Homes (Scotland) Act, [17 & 18 Geo 5. Ch 17].

<sup>23</sup> NAS, CMB 1/3, CMB Minutes, 28 May, 1925, Vol 10, p 17.

<sup>24</sup> NAS, CMB 1/3, CMB Minutes, 26 August, 1926, Vol 11, p27.

<sup>25</sup> NAS CMB, 2/10-14, CMB Report, 31 March, 1926, p 9.

<sup>26</sup> NAS, CMB 1/3, CMB Minutes, 16 December, 1926, Vol 11, p 42.

The Bill did not go through Parliament without some controversy. Section 1 (2) of the principal Act included the ‘habitually and for gain’ phrase.<sup>27</sup> An amendment to this stated:

If any person being either a male person or a woman not certified under this Act attends a woman in childbirth otherwise than under the direction and supervision of a duly qualified medical practitioner, that person shall, unless he or she satisfies the court that the attention was given in a case of sudden or urgent necessity, or in a case where reasonable efforts were made to obtain the services of a duly qualified medical practitioner or of a person certified under this Act, be liable to a summary conviction to a fine not exceeding ten pounds.<sup>28</sup>

This amendment contained two important changes: firstly, the inclusion of the words ‘male person’. The principal Act contained an anomaly in that it omitted to forbid midwifery practice by unqualified men. There is no mention in the CMB Minutes of unqualified ‘male persons’ making a habit of attending women in childbirth. However the non-inclusion of the words ‘male person’ in the principal Act was a loophole which was better closed. The Midwives and Maternity Homes Act 1926 for England and Wales made a similar amendment.<sup>29</sup> The second important change was the exclusion of the words ‘habitually and for gain’, controversially included in the principal Act. This represented the closing of another loophole. Since 1 January 1922 it was illegal for any uncertified woman to attend a woman in childbirth ‘habitually and for gain’. However, it still appeared to be quite easy to get round this obstacle by claiming that the situation was an emergency.<sup>30</sup>

The amendment to the Bill, provoked argument in the House of Commons during the Bill’s second reading. The words ‘habitually and for gain’ made the administration of

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<sup>27</sup> 1915 Midwives (Scotland) Act, 1 (2).

<sup>28</sup> Midwives and Maternity Homes (Scotland) Act, 1927, [17 and 18 Geo.5. Ch.17.]1 (2).

<sup>29</sup> J Donnison, Midwives and Medical Men (New Barnet, Historical Publications, 1988), p 181.

the Act very difficult and it was necessary to tighten up the position. However, James Maxton, MP for a Glasgow constituency, criticised the proposed change on the grounds that the onus should be on the police rather than the neighbour to prove whether or not it was an emergency.

that woman neighbour, who has run in out of decency to lend her assistance to her neighbour in need, must prove that she acted in a case of sudden necessity ... It is quite wrong that the onus of proof should be put on the woman. The onus of proof should be on the police or the authorities to say that the woman is doing this habitually and for gain and not merely as a case of emergency.<sup>31</sup>

Despite Maxton's argument, the Bill moved forward. The section omitting the words 'habitually and for gain' remained, although George Hardie, MP for Glasgow Springburn, asked for reassurance that if a neighbour went 'in to give some assistance and a fatality occurs' she would be protected. Discussion between the SBH and the CMB Chairman and Secretary led to another amendment<sup>32</sup> which made it the LAs' responsibility to provide midwives in cases where none was available. As Barclay-Harvey, MP for Kincardineshire said, 'It was urged in Committee that... we were not doing anything to help poor people to get maternity treatment, and this Clause has been designed to meet this point ... it will now be possible to arrange to give this necessary assistance in all cases'.<sup>33</sup> The House passed this amendment and another clarifying the position relating to the practice of pupil midwives and medical students.<sup>34</sup>

There appeared to be no dissension in the Commons about Part 2 of the Bill dealing with the registration and inspection of maternity homes. When the Act received

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<sup>30</sup> NAS, CMB 2/10-14, CMB Report, 31 March, 1926; cases of this sort probably came to light when a birth was notified which was/is a statutory requirement.

<sup>31</sup> Hansard, Commons, Vol 203, 18 March, 1927, col 2400.

<sup>32</sup> NAS, CMB 1/4, CMB Minutes, 16 June, 1927, Vol 12, p 20.

<sup>33</sup> Hansard, Commons, Vol 207, 24 June, 1927, col 2278.

<sup>34</sup> 1927 Midwives and Maternity Homes (Scotland) Act, 1 (2).

the Royal Assent on 29 July, 1927 the Board agreed to include copies of the Act in the forthcoming issue of the Midwives' Roll to ensure wide awareness of its contents.<sup>35</sup> Thus, registration of maternity homes came under strict control from January 1928<sup>36</sup> and could be cancelled or refused where appropriate.<sup>37</sup> The SBH had the power to make regulations regarding record-keeping of everything that occurred in the homes and details of employees and patients.<sup>38</sup> An important part of the Act gave officers of a LSA and/or the SBH the authority to enter and inspect premises used, or believed to be used, as a maternity home and inspect any relevant records.<sup>39</sup> A LSA also had the power to exempt or not, certain institutions from Part 2 of the Act.<sup>40</sup>

The Act kept the issue of maternal mortality in the public eye, though it was to be at least a decade before an appreciable difference in the MMR was observed. As LAs were now responsible for inspection and registration of maternity homes their powers were further extended. The Act did not give the CMB any new responsibilities regarding midwifery practice. Nevertheless the amendments to the principal Act implemented in the 1927 Act clarified the situation regarding the law and practice of howdies and the use of maternity homes. Towards these ends the CMB worked fully with the SBH.

### **The 1935 Report on Maternal Morbidity and Mortality**

In 1929, the Department of Health for Scotland (DHS) replaced the SBH. The DHS was pro-active in recognising the need for further work in the field of maternal morbidity and

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<sup>35</sup> NAS, CMB 1/4, CMB Minutes, 18 August, 1927, Vol 12, p 23.

<sup>36</sup> 1927 Midwives and Maternity Homes (Scotland) Act, 9 (1).

<sup>37</sup> Ibid, 10 and 11.

<sup>38</sup> Ibid, 12.

<sup>39</sup> Ibid, 13 (1).

<sup>40</sup> Ibid, 15, (1), (2), (3) and (4).

mortality and commissioned another investigation into maternal deaths in Scotland. This resulted in the Report on Maternal Morbidity and Mortality, published in 1935. The committee headed by Dr Charlotte Douglas and Dr Peter McKinley, inquired into reports of 2,527 maternal deaths in Scotland between October 1929 and the beginning of 1933. This figure represented nearly all the maternal deaths in Scotland in this period.<sup>41</sup>

Another DHS-commissioned Committee (Cathcart) met in the 1930s and reported in 1936 on the serious overall health problems in Scotland which impinged on the MMR.

The Douglas and McKinley Committee also investigated midwifery practice and education. This involved sending a questionnaire with the CMB's support, to all practising midwives in Scotland and asking the Board about the training and system of registration of midwives in Scotland.<sup>42</sup> The CMB responded by explaining the purposes of the 1915 Act and how the CMB worked. It also pointed out that a midwife was a person whose name was on the Roll, whether she was practising or not. A further important point was the estimate that of those who took and passed the examination of the CMB, only ten per cent entered midwifery practice. The others were maternity nurses responsible to the doctors under whose instructions they were acting, health visitors and those in other posts, for example, administration, who had no intention of practising as a midwife but where it was an advantage to have the CMB qualification.<sup>43</sup> This represented considerable wastage of resources and depleted the anticipated numbers of practising midwives.

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<sup>41</sup> DHS, Report on Maternal Morbidity and Mortality in Scotland, (Edinburgh: HMSO, 1935), p 5, Douglas and McKinley Report; The authors of the Report acknowledged their gratitude to Dr James Haig Ferguson (CMB Chairman) who studied every completed maternal death report received and who died in 1934 before the Report was published: Douglas and McKinley Report, p 29; There was a shortfall of about twenty deaths per year for which figures were not obtainable.

<sup>42</sup> NAS, CMB 1/5, CMB Minutes, 12 May, 1932, Vol 17, p18; Ibid, 13 October, 1932, p 23; NAS, CMB 1/5, CMB Minutes, 22 November, 1934, Vol 19, p 34.



The Douglas and McKinley Report on Maternal Morbidity and Mortality in Scotland was published in 1935. It identified a common tendency to over-emphasise the dangers of childbearing and stressed the fact that ‘pregnancy and parturition are natural physiological processes’.<sup>44</sup> Nevertheless, the Report indicated the wide need for improvement across the maternity services in Scotland with thirty-nine conclusions and recommendations. The DHS used many of these recommendations when it came to compiling the Maternity Services (Scotland) Bill, enacted in 1937.

While the Report emphasised the need for co-operation from childbearing women, it also criticised standards of maternity care. The authors considered antenatal care to be inadequate and recommended that it should be much more thorough. Twenty-eight per cent of the 2,465 maternal deaths studied for the investigation, were classified as due to lack of adequate antenatal care. Of these, fifty-seven per cent of the mothers were considered to be at fault because they did not ask for antenatal care. In 143 cases, mothers started antenatal care but either they or their relatives ‘refused to follow or ignored the advice prescribed’. The Report also ascribed three hundred of the maternal deaths investigated to inadequate antenatal care on the part of doctors, midwives, or institutions although there was evidence that the mothers had consulted one or other of these services. The authors of the Report also found fault with those providing intranatal care and concluded that many women in Scotland did not receive adequate care.<sup>45</sup>

An important issue was that of ‘meddlesome midwifery’ by general practitioners.<sup>46</sup> The Report commented that ‘it seems fairly obvious that interference

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<sup>43</sup> *Ibid*, 20 December, 1934, p 42.

<sup>44</sup> *Douglas and McKinley Report*, p 24.

<sup>45</sup> *Ibid*, pp 25, 26, 15, 16, 27.

<sup>46</sup> *Ibid*, p 27.

during parturition is an important and preventable contributory factor in the total maternal death rate'.<sup>47</sup> This view was supported by Dr John Munro Kerr, Professor of Midwifery at the University of Glasgow, who found that in the years 1929-31 in Glasgow, where a doctor was in charge of a delivery which happened in many middle class households, the MMR was 5.04. In working class homes where a midwife was usually in charge the MMR was 2.6. In 1928, similar findings were found in Aberdeen. In England and Wales, findings of the Registrar General in 1931 showed that maternal mortality was higher in social classes I and II, (mostly delivered by doctors), than in IV and V, where midwives were in charge.<sup>48</sup> Thus, the difference depended upon the birth attendant. Susan Williams, researching childbirth in the twentieth century, quoted a retired Welsh midwife: 'In those days on the district, the doctors didn't worry. They never waited for the mother to be fully dilated. They would just put on the forceps and try and bring out the baby. They would tear the mother to bits'.<sup>49</sup> However, Dr John MacLeod, in his MD Thesis submitted to the University of Aberdeen in 1935, attempted to justify the position of the general practitioner (GP) in midwifery practice. 'On reading various reports dealing with maternal mortality and morbidity, one feels that the General Practitioner is too often made the scapegoat'.<sup>50</sup> Drawing on his own experience, he refuted the suggestion that GPs were to blame.

My own experience of 1038 maternity cases with only one death and no deaths from sepsis, entitles me to have definite views on midwifery as conducted in the home, and on the effectiveness of the GP provided he is given proper encouragement by the administrative bodies.

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<sup>47</sup> Ibid, p 10.

<sup>48</sup> Loudon, Death in Childbirth, p 244.

<sup>49</sup> A S Williams, Women and Childbirth in the Twentieth Century, (Stroud: Sutton Publishing Limited, 1997), p 59.

<sup>50</sup> J MacLeod, Notes on Maternal Mortality and Morbidity with Special Reference to Maternity Work in General Practice, (Unpublished MD Thesis, University of Aberdeen, 1935), p 10.

The tendency is to disparage his efforts, regardless of the wonderful service he has given in the past, under the most adverse conditions, Certain members ... would have the practitioner replaced by a glorified midwife on the one hand, and by the specialist on the other.<sup>51</sup>

The Douglas and McKinley Report recommended that before any instrumental delivery was anticipated, the person looking after the labouring woman should obtain advice from an obstetrician and whether doctor or midwife, that person should have direct access to the nearest hospital and where necessary bring help to the patient rather than transporting the patient to the hospital.<sup>52</sup> This recommendation was incorporated into the statutes of the 1937 Maternity Services (Scotland) Act.<sup>53</sup> Yet Anne Bayne, describing life as a midwife in the 1950s and 1960s remarked that the GP still had a pivotal role. Contrary to the recommendations, in practice, the midwife still had to have the GP call for specialist help.

It was shocking then that you couldn't on your own [as a midwife] call out a flying squad and a doctor couldn't phone from home. The doctor had to say, 'Yes, I've been to see her, [the patient] yes we need the flying squad'. He couldn't even on the midwife's say so get the flying squad. I had Kenneth Gordon - he would have gone to jail for it. He used to say, 'You're the bloody expert. You don't need me to come and stand and say yes,' and he would do it [get the flying squad on the midwife's instruction before he saw the mother] but he was putting his nose on the line. He could have been struck off for doing it.<sup>54</sup>

The 1935 Report also highlighted postnatal problems, especially relating to infection, stating that these were partly the fault of the patient or relatives due to poor or neglectful care. Nevertheless, the Report attributed fifty-six puerperal deaths dominated by sepsis, to lack of adequate professional care<sup>55</sup> and made three recommendations for

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<sup>51</sup> *Ibid.*, p 2.

<sup>52</sup> *Douglas and McKinley Report*, p 28.

<sup>53</sup> 1937 *Maternity Services (Scotland) Act*, 1937, [1 Edw 8 & 1 Geo 6 ], 1, (2e).

<sup>54</sup> *Oral testimony*. For details of the oral interviews conducted in relation to this research, see Appendix 4. LR, 21 [91].

<sup>55</sup> *Douglas and McKinley Report*, p 24.

postnatal care. Firstly, LAs should ensure that the frequently disregarded rule requiring notification of puerperal pyrexia was strictly obeyed.<sup>56</sup> Secondly, nobody suffering from an infection should be near a puerperal woman. Thirdly, there should be better arrangements for six-week postnatal examinations to reduce morbidity later.<sup>57</sup>

The Report made further recommendations particularly to do with midwives which appeared in the 1937 Maternity Services (Scotland) Act. There was a need for closer partnership between midwives and LAs. In addition the Report reiterated the dangers of maternity nursing carried out by people other than a midwife.<sup>58</sup> However, as well as this, to make a maternity service work, co-operation from the mothers and co-ordination between everyone who had anything to do with providing the service were needed.

While the Douglas and McKinley Committee specifically investigated maternal mortality and morbidity, the DHS was aware of serious overall health problems in Scotland in the first decades of the twentieth century that were relevant to the MMR. In 1933 the DHS commissioned the Committee on Scottish Health Services chaired by E D Cathcart, with a remit to review, investigate and report on the serious problems of Scotland's health. The Cathcart Committee reported on 1 July 1936.<sup>59</sup> The main theme was to draw all the disparate threads of current health care into one national health policy.

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<sup>56</sup> See this chapter, footnote 4.

<sup>57</sup> Douglas and McKinley Report, p 28.

<sup>58</sup> Ibid, p 29.

<sup>59</sup> J Brotherston and J Brims, 'The Development of Public Medical Care: 1900-1948', in G McLachlan, ed, Improving the Common Weal: Aspects of Scottish Health Services, 1900-1984, (Edinburgh: Edinburgh University Press, 1987), p 75.

From the aspect of the maternity services and the MMR the Cathcart Report reinforced the findings of the Douglas and McKinley Report published a year earlier.<sup>60</sup>

### **The 1937 Maternity Services (Scotland) Act**

When the 1936 Midwives Act for England and Wales was passed, the DHS agreed to work for a similar Scottish Act. In presenting the Maternity Services (Scotland) Bill to the Commons in January 1937, Walter Elliot, the Secretary of State for Scotland (SOS), said that the Bill was intended 'to deal with a stubborn and intractable problem which, for long, has preoccupied those who are engaged in the public health service in Scotland ... maternal mortality'.<sup>61</sup> In the debate, James Guy, MP for Central Edinburgh, compared the Scottish MMR of six with an English MMR of four.<sup>62</sup> Neither Elliot nor Guy made reference to the problems, already mentioned, in comparing the MMR between Scotland and England and how, according to the Salvesen Report, they were not very different.

The Scottish Bill broke new ground because the 1936 Midwives Act for England and Wales made provision for midwives only. This differed from the objectives of the Scottish Bill which were more comprehensive and planned to provide an improved maternity service in Scotland with greater involvement of LAs.<sup>63</sup> Echoing the recommendations of the Douglas and McKinley Report, Elliot envisaged that mothers in Scotland having a home birth would be entitled to the services of a midwife, doctor, and

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<sup>60</sup> DHS, Committee on Scottish Health Services Report, Cmnd. 5204, The Cathcart Report, (Edinburgh: HMSO, 1936), Chapter XIV, Maternity and Child Welfare, pp 170-182.

<sup>61</sup> Hansard, Commons, Vol 319, 28 January, 1937, Cols 1099-1155.

<sup>62</sup> Ibid.

<sup>63</sup> Hansard, Commons, Vol 317, 10 November, 1936, Cols 698-699; S M Herbert, Britain's Health, (Harmondsworth: Penguin Books Ltd, 1939), p 138.

obstetrician if necessary, working together as a team.<sup>64</sup> The 1937 Maternity Services (Scotland) Act received the Royal Assent on 6 May, 1937.

This Act was divided into ten Sections followed by two Schedules. It laid the responsibility on LAs to provide for the services of certified midwives to attend women in their own homes 'before and during childbirth and from time to time thereafter during a period not less than the lying-in period'<sup>65</sup>. The 1936 Act for England and Wales specified fourteen days for lying-in. The Scottish Act made no such specification therefore allowing the CMB flexibility in this.<sup>66</sup> Midwives had to be certified but otherwise could be from any source, including employment by LAs, thus establishing a salaried midwifery service. LAs were also responsible for arranging for medical care of women having babies at home including, as well as the GP, the services of an anaesthetist and obstetrician where necessary.<sup>67</sup> LAs had to submit their proposed arrangements for maternity care to the DHS and all appropriate bodies involved in maternity care in the area including medical schools and midwifery training institutions for negotiation and/or approval.<sup>68</sup>

Implementation of the Act had financial implications which affected all concerned and there was prolonged discussion in the Commons on the issue of means-testing and fees for maternity services. In order to provide improved maternity services for every woman, the Act authorised LAs to recover part or all of the fees if possible. Fees were payable on a scale approved by the DHS,<sup>69</sup> based on a formula weighted according to the

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<sup>64</sup> Hansard, Commons, Vol 319, 28 January, 1937, Cols 1099-1155.

<sup>65</sup> 1937 Maternity Services (Scotland) Act, 1 (1).

<sup>66</sup> Hansard, Commons, Vol 319, 28 January, 1937, Cols 1099-1155; NAS, CMB 1/5, CMB Minutes, 19 March, 1937, Vol 22, p 8.

<sup>67</sup> 1937 Maternity Services (Scotland) Act, 1 (2).

<sup>68</sup> Ibid, 1 (3-11)

<sup>69</sup> Ibid, 2.

special needs of an area.<sup>70</sup> Improved maternity services meant increased expenditure for LAs and to help LAs with this, the Act made provision for extra finances to be provided by Parliament. This was in line with the intention of the Local Government (Scotland) Act 1929 which provided for financial help for LAs coping with additional expenditure due to the institution of a new service.<sup>71</sup>

The new maternity service also had an impact on midwives' working and financial arrangements. A more formal structure of payment meant that for midwives employed by LAs, life would be more secure than hitherto when they often went without payment.<sup>72</sup> On the other hand, some midwives might be unable to comply with the terms and conditions of formal LA employment and the Act provided recompense for a certified midwife who stopped practising within three years of the Act or retired because her LA considered her unable to continue practising. In these cases Parliament reimbursed LAs for half of the money paid out as compensation to midwives, and midwives had to surrender their certificate of enrolment for cancellation.<sup>73</sup>

The Act tackled again the old question of unqualified midwifery practice and again included the deterrent of a ten-pound fine.<sup>74</sup> This was a further attempt to eliminate howdies in Scotland and MPs expected it to happen.<sup>75</sup> However, as Anne McFadden recalls, howdies were to be seen working in Fife as late as the 1950s.

They [the howdies] would have a very... minimal training. The doctors would have taken them out with them... very often they were widows... who maybe... needed some extra money... they most definitely weren't certified midwives. They would assist him and through just being there and seeing what was done they would be

<sup>70</sup> Hansard, Commons, Vol 319, 28 January, 1937, cols 1099-1155.

<sup>71</sup> 1937 Maternity Services (Scotland) Act, 3 (1).

<sup>72</sup> Hansard, Commons, Vol 319, 28 January, 1937, cols 1099-1155.

<sup>73</sup> 1937 Maternity Services (Scotland) Act, 4.

<sup>74</sup> Ibid, 6 (1).

<sup>75</sup> Hansard, Commons, Vol 319, 28 January, 1937, cols 1099-1155.

able to do the normal. The only problems would be, would they know when to send for the doctor ... if there was difficulty, but they did quite well and they would make a reasonable living out of it.<sup>76</sup>

In a further attempt to reduce the MMR by improving and maintaining midwives' skills, the Act also provided for the CMB to frame Rules for midwives' refresher courses and for LAs to arrange for midwives' attendance at them.<sup>77</sup> Refresher courses for midwives were not a new concept and started in Scotland, first in 1927 at Govan Maternity Home and in 1928 in Edinburgh, at the instigation of the SMA.<sup>78</sup> However, these were irregular and not compulsory. After the 1937 Act was passed it became a statutory requirement for all midwives to attend refresher courses to keep up to date with current trends although the CMB waived this for a time during and after World War II.

### **Extending the length of midwifery training**

In accordance with the recommendations of both the Salvesen, and Douglas and McKinley Reports, and the 1937 Maternity (Services) Act, the CMB extended the length of midwifery training in the 1920s and 1930s and adjusted the Rules correspondingly. This involved issues of reciprocity and difficulties working with other Boards, as well as problems persuading midwifery training institutions in Scotland of the need for extension. The first of the extensions had a planned start date of 1 January 1926 when midwifery training was to lengthen to twelve months for women who were not nurses and six months for those who were. The plan evolved over the previous five years and was initiated and maintained by correspondence between the CMBs for Scotland, England

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<sup>76</sup> LR, 36 [108].

<sup>77</sup> 1937, Maternity Services (Scotland) Act, 7 (1), (2).

<sup>78</sup> NAS, CMB 1/3, CMB Minutes, 5 May, 1927, Vol 11, p 15; NAS, CMB 1/3, CMB Minutes, 20 September, 1928, Vol 13, p 20.



and Wales, and Ireland and their counterparts from Victoria, Australia, Western Australia, Queensland, Australia and Wellington, New Zealand.<sup>79</sup> Reciprocity was therefore not just a question of the 'home Boards' agreeing to allow each other's midwives to cross borders. It was also an issue of agreeing to each other's length and content of training and taking into account what other countries were doing.

Because it involved correspondence between so many Boards, the extension of the midwifery course was a recurring issue. To begin with, there were difficulties in the relationship between the CMB (E&W) and the Scottish Board. Both Boards wished reciprocity with the Dominions, whose midwives had a longer training, but at the outset they agreed that they could not lengthen the midwifery course at that time.<sup>80</sup> Then the CMB (E&W) made a series of decisions without consulting the Scottish Board: it announced its decision to extend the period of midwifery training;<sup>81</sup> it sent the Scottish CMB ready-made additions and alterations to the Rules for lengthening the midwifery course;<sup>82</sup> finally, it failed to inform the Scottish Board until afterwards, that it had changed the projected start date of the new course.<sup>83</sup> On each occasion the Scottish Board went along with the plans and changes of the CMB (E&W) because it considered reciprocity to be very important. Nevertheless, the lapses in professional etiquette did not go un-noticed, and the Scottish CMB reminded the CMB (E&W) of the desirability of working together.

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<sup>79</sup> NAS, CMB 1/3, CMB Minutes, 29 September, 1921, Vol 6, p 40; NAS, CMB 1/3, CMB Minutes, 11 May, 1922, Vol 7, p 20; NAS, CMB 1/3, CMB Minutes, 21 June, 1923, Vol 8, p 23; Ibid, 22 November, 1923, p 43.

<sup>80</sup> NAS, CMB 1/3, CMB Minutes, 17 November, 1921, Vol 6, p 49.

<sup>81</sup> NAS, CMB 1/3, CMB Minutes, 15 March, 1923, Vol 8, p 7; NAS, CMB 1/3, CMB Minutes, 15 March, 1923, Vol 8, p 8.

<sup>82</sup> NAS, CMB 1/3, CMB Minutes, 24 April, 1924, Vol 9, p 15.

<sup>83</sup> NAS, CMB 1/3, CMB Minutes, 16 June, 1924, Vol 9, p 25; Ibid, 27 June, 1924, p 27; Ibid, 18 December, 1924, p 47; NAS, CMB 1/3, CMB Minutes, 12 March, 1925, Vol 10, p 10.

The CMB kept staff of training institutions, the SBH and the GMC informed of the progress of negotiations over the length of the training period. It sent copies of the new Rules to approved training institutions but on the whole left each to adapt its methods and curriculum to suit local circumstances. However it was anxious about the attitudes of the heads of training institutions to the proposed changes. In a memorandum accompanying the new Rules, the CMB justified the extension on the basis of the current anxiety about maternal and infant mortality: 'The immediate objective of the Board is to improve the training of women for the office of midwife, in the hope that thereby mortality and disability may be lessened among the mothers and babies of the nation.'<sup>84</sup> With this in mind, the memorandum went on to make some specific instructions about midwifery training. The first concerned general education. While there was no set standard of education for entry to midwifery training in the 1920s, the CMB, in a major change from the 1916 Rules, instructed institutions to be sure that prospective pupil midwives had a reasonable standard of education. Thus they could refuse illiterate pupils at the outset or discontinue their training at an early stage.<sup>85</sup> Secondly, the CMB stated that the extended midwifery training should include the hitherto low profile antenatal care which acknowledged its importance and its anticipated place in lowering the MMR. Thus, institutions could use the current expansion of antenatal clinics and care as opportunities for instruction of pupil midwives in 'the hygiene of pregnancy, in abdominal palpation, in the care and treatment of the minor disturbances of pregnancy,

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<sup>84</sup> *Ibid*; *Ibid*, 28 May, 1925, p 18; *Ibid*, p 19.

<sup>85</sup> *Ibid*, 28 May, 1925, p 20. The fact that the CMB felt the need to tell a training institution that they could refuse illiterate women indicates the low level at which midwifery and maternity care was still held.

and in the examination of urine'.<sup>86</sup> Thirdly, the Board stipulated an increase in mandatory lectures from twenty to thirty, and finally a requirement for pupils to witness ten births before starting to deliver babies personally. The first five deliveries of a minimum twenty 'cases' had to be attended in the approved training institution and of the remaining fifteen, at least five should be in the mothers' own homes.<sup>87</sup>

The Board's anxiety over the possible attitude of heads of training institutions in Scotland on the proposed extension of training was justified. The major problem was financial – for both training institutions and midwives. For example, in 1925, the management of Glasgow Royal Maternity Hospital (GRMH) stated that unless the hospital received help from public money, the extended midwifery training would cost it nearly £4,000 per year and increased training fees would be a disincentive to would-be midwives;<sup>88</sup> a view reinforced by Dr A K Chalmers, Board member and also MOH for Glasgow. Current training charges at GRMH were £25 and £36 and any increase was likely to lead to poor recruitment with a subsequent drop in services, thus negating any proposed improvement in the MMR through extending midwifery training.

There was also a discrepancy in Government funding of midwifery training between England and Wales and Scotland. In 1919 the Treasury awarded a grant of £20 to each pupil midwife in England and Wales who guaranteed to practise on qualification.<sup>89</sup> With the proposal to lengthen the training as a means to helping to lower the MMR the Ministry of Health was prepared raise the grant to £35. This was not

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<sup>86</sup> NAS, CMB 1/3, CMB Minutes, 26 June, 1924, Vol 9, p 26; NAS, CMB 1/3, CMB Minutes, 28 May, 1925, Vol 10, p 21; although antenatal care was increasingly prominent in the midwifery curriculum, in practice, midwives found that their role in this field was small. See chapter 6, Antenatal Care.

<sup>87</sup> NAS, CMB 1/3, CMB Minutes, 28 May, 1925, Vol 10, p 18.

<sup>88</sup> NAS, CMB 1/3, CMB Minutes, 5 February, 1925, Vol 9, p 50.

<sup>89</sup> J Towler and J Bramall, Midwives in History and Society, (London: Croom Helm, 1986), p 205.

available in Scotland.<sup>90</sup> The Midwives (Scotland) Act stated, 'LSAs are hereby authorised to contribute towards the training of midwives within or without their respective areas in such a manner and to such an extent as may be approved by the LGBS'.<sup>91</sup> Thus, at the time, help from LAs was neither standard nor compulsory. James Maxton MP, speaking in the Commons in 1927 when the Midwives and Maternity Homes (Scotland) Bill was under discussion, highlighted the lack of financial help when he said

The Act [Midwives (Scotland) Act 1915] imposed the duty of giving training to these people [pupil midwives]...on these public institutions, which are entirely voluntary and...have made absolutely no allowance out of public funds for the extra responsible duties that are taken on, although the corresponding function carried out by hospitals in England...is very definitely subsidised out of public funds. The same job in England is regarded as a national responsibility whereas in Scotland the duty is put on maternity hospitals, and they are supposed to get the money for the training of the nurses (sic) any way they please.<sup>92</sup>

Maxton suggested that it would contribute to the reduction of the MMR in Scotland if intelligent women were attracted into midwifery training and retained within the profession. This required Government financial support which in 1927 in Scotland was not available although soon after, the SBH granted a £20 training grant to selected candidates.<sup>93</sup>

A longer training also had possible financial implications for midwives and mothers. Raised costs for the pupil midwife for tuition and board-and-lodgings meant that she would possibly charge more for her professional services with subsequent increased costs to impecunious mothers.<sup>94</sup>

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<sup>90</sup> D Dow, *The Rottenrow*, (Carnforth: The Parthenon Press, 1984), pp 152 and 153.

<sup>91</sup> *1915 Midwives (Scotland) Act*, 21.

<sup>92</sup> *Hansard*, Commons, Vol 203, 18 March, 1927, col 2398.

<sup>93</sup> Dow, *The Rottenrow*, p 152.

<sup>94</sup> Towler and Bramall, *Midwives in History and Society*, p 206.

The problem of students' finances was gradually alleviated during the 1930s as pupil midwives' fees in, for instance, the Maternity Hospital, Bellshill, were reduced and finally eliminated, and replaced by a salary to aid recruiting to that hospital and thus improve the local midwifery service.<sup>95</sup> However this was not standard at the time across Scotland. Linda Stamp, training in Rottenrow in the early 1940s recalled: 'We had to pay £50 for our training and got no salary.'<sup>96</sup> The recruitment fears articulated by the GRMH management at least, were unfounded.

Thus, the extension of midwifery training went ahead in 1926. However, the anticipated reduction in the MMR did not happen.

### **Further extension of midwifery training**

In the 1930s, the CMB (E&W) wanted to extend the length of midwifery training again. Its members argued that this was required because of the continuing high MMR in Britain. The MMR in several continental countries, especially Holland was significantly better than in Britain. Training times there and midwifery service organisation were different and the CMB (E&W) hoped that if they made changes to match, 'equally favourable results would be attained'.<sup>97</sup> The CMB for Scotland refuted the idea that midwifery training was too short and noted that any evidence had come solely from Ministry of Health Departmental Committees' Reports. The equivalent DHS investigation commissioned in 1929, had not reached report stage.<sup>98</sup> Nevertheless, it was important to reach agreement; otherwise the proposals would affect reciprocity within

<sup>95</sup> Caldwell, E, *Sixty Glorious Years*, (Paisley: James Paton, 1982), p 10.

<sup>96</sup> LR, 4 [115].

<sup>97</sup> NAS, CMB 1/5, *CMB Minutes*, 2 November, 1933, Vol 18, p 39.

<sup>98</sup> *Ibid*; the equivalent Report for Scotland in this instance was the 1935 Douglas and McKinley Report.

Britain and Ireland and throughout the Empire. To settle the matter the CMBs agreed not to make any final decisions until they had ironed out any dissensions at a conference of Board representatives.<sup>99</sup>

The CMB anticipated other problems: the proposals were likely to reduce entrance to the Roll by about a half with the consequent supply of midwives not meeting the needs of the public; the cost of producing a midwife would be greater and the proposals did nothing to assist the economic difficulties which midwives encountered. Furthermore, the proposals would probably affect the current organisation of the training schools. The Board acknowledged the need for vigilance, Rule changing and improving standards. Yet it recommended much more in the way of discussion between the Boards and with training institutions before contemplating any big changes.<sup>100</sup>

This came to fruition in June 1934 in a conference of Board representatives chaired by Dr John Fairbairn, obstetrician and author of numerous midwifery textbooks, representing the CMB (E&W).<sup>101</sup> Dr Bruce Dewar, representing the Scottish Board, specified the difficulties that the CMB for Scotland had with the proposals for extension of midwifery training and described the extensive, but as yet incomplete, inquiries into maternal mortality and medical services in Scotland. Thus, he argued that the CMB for Scotland should not 'take premature action'. However, Dr Fairbairn held that an extension in training was due. All concerned perceived the increase in antenatal care to be important in lowering the MMR. However, this meant that there was more to be taught and the present training was too short and overcrowded.

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<sup>99</sup> NAS, CMB 1/5, CMB Minutes, 2 November, 1933, Vol 18, p 37; Ibid, 27 April, 1933, p 18.

<sup>100</sup> Ibid, 2 November, 1933, p 40.

<sup>101</sup> NAS, CMB 1/5, CMB Minutes, 26 July, 1934, Vol 19, p 24.

The discussion included two potentially far-reaching issues. One was whether to exclude women who were not registered nurses from midwifery training, an issue which arose many times over the years. In 1929 in the Transactions of the Edinburgh Obstetrical Society, Dr James Young, an Edinburgh obstetrician, expressed the hope 'that these [nurse] trained midwives would be produced in such large numbers that there would soon be little or no room to take the untrained'.<sup>102</sup> But there was no change until 1968 when the CMB put a stop to non-nurses entering midwifery training in Scotland although the CMB (E&W) kept the door open for them in Derby and the Whittington Hospital, London.<sup>103</sup> The other issue was the possibility of 'nurses of all types' having a general training before branching into specialties. The delegates at the Conference opined that the future wider role of the midwife carrying what they described as greater responsibility for antenatal care, normal labour and 'motherhood' education would require a more extensive course than was currently offered. It is unclear from the 1934 Conference Report whether midwifery was included in the suggestion about branches of nursing although this is implied.<sup>104</sup>

The 1934 Conference eventually facilitated agreement. In conjunction with the other Boards, the CMB decided to extend the period and change the format of midwifery training. The new course was in two parts, the first of which was six months for pupil midwives who were already nurses and eighteen months for non-nurses. The second part

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<sup>102</sup> J. Young, 'A Scheme of Maternity Service Co-ordinating Antenatal Treatment, Domiciliary and Hospital Treatment', The Transactions of the Edinburgh Obstetrical Society, Session LXXXVIII, 1928-1929, pp 95-107. (Reproduced in Edinburgh Medical Journal, New Series, Vol. XXXVI., No. 6, June 1929).

<sup>103</sup> This was to be another bone of contention between the Boards when discussing the EEC Midwifery Directives.

<sup>104</sup> NAS, CMB 1/5, CMB Minutes, 26 July, 1934, Vol 19, p 24; The idea of 'branches' of nursing was discussed in the 1972 Briggs Report before being put into action in the late 1980s and 1990s when the nursing and midwifery curricula were changed and upgraded. Although there was an effort to include midwifery in the nursing branches, midwives decided against it.

was six months for all. This extended the training time to accommodate the widening midwifery curriculum. The two part course was also an effort to dissuade nurses who had no desire to practise midwifery from taking the full training. As already mentioned above, this custom represented considerable wastage of resources and depleted the anticipated numbers of practising midwives. The Boards hoped that prospective employers of senior grade nurses would look on Part 1 midwifery as being sufficient for the purpose, thereby saving resources.<sup>105</sup>

The DHS approved the current CMB Rules until March 1939, so that the CMB could take into account the recommendations of the Douglas and McKinley Report and the statutes of the 1937 Maternity Services (Scotland) Act when framing the new Rules.<sup>106</sup> They were effective from March 1939 just after the start of the new extended midwifery course in December 1938.

By 1939 the MMR in Scotland was reduced to just under 5 per 1000 births with a further reduction from 4.4 to 2.8 in the years 1940-1945. Important factors in the reduction of the MMR included: improved education and practice of midwives and doctors; greater awareness of potential problems; the development of blood transfusions; the use of sulphonamides in the control of sepsis; and, from the social aspect, improved standards of living with improved nutrition.<sup>107</sup>

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<sup>105</sup> M Uprichard, 'The evolution of midwifery education', in Midwives' Chronicle, January 1987, pp 3-9.

<sup>106</sup> NAS, CMB 1/5, CMB Minutes, 19 March, 1937, Vol 22, p 7.



## Conclusion

During the inter-war years the CMB found itself in the thick of a concerted effort to reduce the MMR in Scotland. Working alongside LAs and the DHS, its members had to comment upon the 1924 and 1935 reports of Departmental Committees of the DHS investigating maternal morbidity and mortality and consider the wider-ranging 1936 Cathcart Report. The Board also had a significant role to play in the framing of the 1937 Midwives (Scotland) Act. Along with its day-to-day work with penal cases and correspondence, the Board had to work with other Boards while trying to maintain an element of its own independence and identity. Work on reports and further midwifery legislation linked with the drive to reduce the MMR led to further Board work extending midwifery courses and compiling new Rules to conform with the 1937 Act and with other Boards.

Minutes are only a bare record of the CMB meetings and do not tell the whole story, but they suggest that the Board functioned very slowly, re-drafting Rules, deciding on the extensions of the midwifery course and working on the MTD course.<sup>108</sup> It tended to carry out its work through committees which only reported monthly. Nevertheless the Board gradually accepted its important part in influencing maternity care in Scotland. In 1923 the Board did not give much help to the Salvesen Committee. Yet, after publication of the Salvesen Committee's Report, the Board was eager to show that it was doing all it could to implement the recommendations of the Report by extending midwifery training with extra antenatal training and working to eradicate howdies through a new Act. This

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<sup>107</sup> Loudon, *Death in Childbirth*, p 255; See also Loudon, *Death in Childbirth*, pp 258-261, for a discussion on the use of antibiotics especially *prontosil rubrum* in puerperal fever, firstly in hospitals and then in general practice.

<sup>108</sup> See chapter 4, p 116 for discussion on the MTD course.

willingness to co-operate and act was repeated when it came to commenting on the 1927 Midwives and Maternity Homes (Scotland) Act, the Douglas and McKinley Report and the 1937 Maternity Services (Scotland) Act.

While the Board's slow committee-bound work is evident in its Minutes there was another factor which slowed proceedings up in Scotland. Governmental and Parliamentary proceedings appear to have played a part in the relative delay in Scottish measures. Scottish matters often lagged behind their English equivalent in Parliament. For instance the 1926 Midwives and Maternity Homes Act (for England and Wales) was implemented a year before the equivalent Scottish Act, which was only accelerated through the energy of the CMB. However, to be second could have advantages. Observation of post-1902 midwifery in England and Wales meant that the 1915 Midwives (Scotland) Act contained clauses which improved upon the 1902 Midwives Act. The 1937 Maternity Services (Scotland) Act was more comprehensive than the 1936 Midwives Act (for England and Wales) and dealt with maternity services as a whole in Scotland and not only midwives as did the Act for England and Wales.

The CMB found it difficult to work with other Boards particularly the CMB (E&W) which was well-established before the 1915 Midwives (Scotland), Act. The Board had a recurring tendency to 'ask England' when it was unsure of how to act. It could have been a question of inexperience, or, of a larger neighbour – the 'in bed with an elephant syndrome'.<sup>109</sup> The Board frequently argued for a point of view but then gave in under pressure. This was particularly obvious at the inter-Board Conference called in 1934 to discuss extending the midwifery courses to include more antenatal care on the

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<sup>109</sup> L Kennedy, *In Bed with an Elephant*, (London: Bantam Press, 1995). Kennedy discusses the problems which arise when one lives next door to a much bigger neighbour.

curriculum with the idea that more widely educated midwives would help to lower the MMR. Here, Board members wanted to wait for the Douglas and McKinley Report on maternal morbidity and mortality to which it had contributed evidence, before deciding to extend the midwifery course in Scotland. Yet, for the sake of reciprocity, the Board eventually agreed to do so. In the event it was nearly five years before the new course started and new Rules published. So, although the Board still went along with its commitment to lengthening the course, it had time in the interim to consider the Douglas and McKinley Report, contribute to discussions on the Maternity Services (Scotland) Act, and convince those in midwifery training institutions in Scotland of the benefits of the changes to mothers in Scotland as well as midwives.

## Chapter 4

### **The CMB: coping with events, 1939-1959**

The first five years of the Board's existence was a time of feeling its way and growing into the job. The second period to 1938 was one of dealing with the longstanding issue of the MMR in Scotland. In the third period from 1939 to 1959 the Board had to cope with issues affecting midwifery in Scotland as a result of events, particularly World War II and the coming of the National Health Service (NHS), which were not specific to Scotland and yet had significant effects on maternity care and midwifery in Scotland.

Before turning to World War II and how it affected midwifery in Scotland, it is necessary to consider two major reviews of the Rules which the Board made between 1939 and 1959. New Rules in 1939 brought changes to the training-periods and examinations for the midwifery course, and the development of the Midwife Teachers' Diploma (MTD) in Scotland. In 1947, the second major review resulted in a complete alteration of the format of the Rules signifying a change in the way the Board viewed midwives. Out, was the uneducated midwife of the early twentieth century and in, was the formally-educated woman of the late 1940s. At the same time there was still confusion over who could practise as a midwife and this chapter examines how the CMB clarified the issue.

World War II affected maternity care. Among other things the war brought refugees from other countries who wanted to train as midwives in Scotland, and it brought problems arising from the shortage of midwives which continued after the war. Also, after the war were new Rules about midwives' training in, and administration of,

inhalational analgesia and I shall examine how the issues in Scotland differed from those in England.

The NHS Acts, implemented in July 1948 brought an administrative structure which fragmented the way childbearing women were cared for, encouraged them to 'book' with their GP when pregnant and thus by-passed the midwife as their first point of contact. I shall examine this, the increasing trend for births to take place in hospital instead of home and the consequent effect on midwifery training and practice.

### **Changes in the Rules**

As discussed in chapter 3, during the 1930s the CMBs agreed to extend the period of midwifery training across the UK. This change required extensive revision to the Rules before they came into effect on 1 March 1939.

Among the most important of the new Rules were those setting up the new two part examinations.<sup>1</sup> Part 1, consisted of a written paper and a clinical oral including antenatal cases and the management of the puerperium. Part 2, at this time was a clinical oral only. The Board framed other new Rules relevant to examinations which included: pupil midwives should not sit examinations in their 'home' hospital; written and oral examinations should be a week apart; any failed written papers should be doubly marked and the clinical oral should have two examiners, both of whom should take part in examining the candidate.<sup>2</sup> The new Rules heralded a fairer, more thorough system of

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<sup>1</sup> NAS, CMB 1/6, CMB Minutes, 29 July, 1938, Vol 23 p 18; like the two Parts of the midwifery course, the examinations were known as Part 1 and Part 2.

<sup>2</sup> NAS, CMB 1/6, CMB Minutes, 21 July, 1939, Vol 24, p 24.

examinations. The first examination under the new Rules of the Board took place on 5 December, 1939.<sup>3</sup>

The division of the examination into two parts gave scope for the appointment of midwives as examiners. Until the early 1940s only medical practitioners were examiners. From February 1941, in line with changes made by the CMB (E&W) and the Joint Nursing and Midwives Council Northern Ireland (JNMCNI),<sup>4</sup> the CMB appointed suitably qualified midwives as examiners for the second examination. The first midwife examiners were Miss Ferlie, Matron at the SMMP, Edinburgh, Miss Holbech, Matron, the Elsie Inglis Memorial Maternity Hospital, Edinburgh and Miss Paton, Matron, GRMH,<sup>5</sup> not as might be expected, midwives with a teaching qualification. The following year, the Board agreed to appoint Sister Tutors in the major Maternity Hospitals to the same role.<sup>6</sup>

The 1939 Rules were approved for five years and, in view of the war, extended for a further five years in 1945.<sup>7</sup> However, in 1946, deciding that the time was right, the Board, through an *ad hoc* committee, began its fifth major revision of the Rules since the 1916 original publication.<sup>8</sup> The first four revisions, in 1918, 1922, 1926 and 1939, repeated the didactic tone of the original Rules. The time had come to simplify the format of the Rules and remove particularly 'do and don't' Rules governing the midwife's duties. These were originally included because of the low educational standard, to the point of near-illiteracy in some cases, of some newly-enrolled midwives in 1916. Thus,

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<sup>3</sup> *Ibid*, 23 February, 1940, pp 35 and 36.

<sup>4</sup> NAS, CMB 1/6, *CMB Minutes*, 26 July, 1940, Vol 25, p 9.

<sup>5</sup> *Ibid*, 21 February, 1941, p 31.

<sup>6</sup> NAS, CMB 1/6, *CMB Minutes*, 20 November, 1942, Vol 26, p 33.

<sup>7</sup> NAS, CMB 1/7, *CMB Minutes*, 27 February, 1945, p 2.

<sup>8</sup> NAS, CMB 1/7, *CMB Minutes*, 31 October, 1946, p 2.

the 1916 Board thought that there should be no room for misunderstandings. By the 1940s there was a higher standard of general education and improved standards of midwifery teaching and practical training. Another feature of the improvement in the background of midwives in the Board's eyes was the very small proportion of non-nurses applying for training. Consequently, the 1947 committee decided to leave details such as 'disinfection of person, clothing and appliances', to be incorporated into the training and argued that the Rules should emphasise general principles rather than minutiae, in a move to make 'the calling of the midwife appeal to intelligent young women with good basic education'.<sup>9</sup> Thus, the committee saw the simplification of the Rules as a way to help recruit suitable candidates to the profession.

To fulfil these aims the Committee recommended major changes which the CMB accepted without apparent controversy. In response to recommendations from the examiners, they proposed to omit the clinical and practical parts of the first examination. Rules B and C were combined in one Rule B and the new Rule C dealt with inhalational analgesia. Rule D covered midwifery practice including the introduction of compulsory refresher courses. Rules E, F and G remained almost as before and a new Rule H pertaining to the MTD was added. This fifth major revision of the CMB Rules was effective from 1 March 1948.<sup>10</sup>

### **Who may act as a midwife?**

In addition to reviewing the Rules and making them more user-friendly, the Board had to attend in the 1940s to the recurring issue of who may act as a midwife. In the late 1930s

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<sup>9</sup> See chapter 2 p 61; NAS, CMB 1/7, CMB Minutes, 20 November, 1947, p 3.

<sup>10</sup> NAS, CMB 1/7, CMB Minutes, 26 February, 1948, p 1.

there was still confusion within LAs about this question. The 1915 Midwives (Scotland) Act, the 1927 Midwives and Maternity Homes (Scotland) Act and the 1937 Maternity Services (Scotland) Act established and enlarged upon the issues of the role of the certified midwife, and who could not act in this role. A woman who was neither a certified midwife nor a registered nurse and who received 'any remuneration for attending ... as a nurse on a woman in childbirth or at any time during the fourteen days immediately after childbirth... shall be liable on summary conviction to a fine not exceeding ten pounds.'<sup>11</sup>

The situation was confused because it depended on how and with whom a midwife was working. Firstly, there were certified midwives working by themselves as midwives. Secondly there were certified midwives attending a woman in labour under the supervision of a doctor, when she could be called a maternity nurse. Thirdly, as the 1937 Act implies, a nurse on the general part of the Register kept by the General Nursing Council (GNC) could attend a woman in labour under the supervision of a doctor but not deliver the baby. Under those circumstances she also could be called a maternity nurse but she was not allowed to act as a midwife.<sup>12</sup> Yet, in November 1938 there was still confusion about nomenclature which required further clarification as midwifery training was now in two parts.<sup>13</sup> If a woman passed Part 1 successfully she then had the right to practise as a maternity nurse under the supervision of a medical practitioner. She was not permitted to practise as a midwife (attending and delivering a mother in labour on her own) unless she had passed Part 2. However the decision whether a woman who had only passed Part 1 could practise in a hospital rested with the authorities of individual

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<sup>11</sup> 1937 Maternity Services (Scotland) Act, [1 Edw 8 & 1 Geo 6 Ch 30], 6 (1).

<sup>12</sup> NAS, CMB 1/6, CMB Minutes, 25 March, 1938, Vol 23, p 7.



hospitals.<sup>14</sup> Alison Dale from Aberdeen described the experience of her mother at the beginning of World War II.

my Mum was a Staff Nurse at Summerfield Maternity Home [in Aberdeen]. She had been there many years...she did her first Part [midwifery] in Glasgow and she finished just at the start of the war. She trained in the Southern General and she was told she would never require her second part because she wouldn't be going into midwifery because she had her sister's post [as a nurse] the day she sat her exam. She never did her second part and so she didn't have second part to do labour ward so she did antenatal for many years.<sup>15</sup>

The management at Summerfield considered Part 1 to be sufficient to work in antenatal but not in the labour ward.<sup>16</sup>

In February 1944 there was still confusion about midwifery practice. The MOH for Greenock asked the Board what was 'a birth attended by a midwife'? The Chief Medical Officer of the DHS, Dr Andrew Davidson, said that it would be wrong to classify cases dealt with under the Maternity Services Schemes of LAs as 'cases attended by midwives'. This was because 'in Scotland, under the maternity services scheme, general practitioners supervise all home confinements'. This did not necessarily mean that doctors carried out the deliveries. The Report of a survey of social and economic aspects of pregnancy and childbirth in Britain undertaken by a Joint Committee of the RCOG, the Population Investigation Committee and the DHS in 1946 stated that 'only twenty-six per cent of rural and eighteen per cent of urban home deliveries in Scotland are actually carried out by doctors'.<sup>17</sup> In many cases the doctor was not present although the midwife was obliged to notify him, firstly when the mother was pregnant and later

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<sup>13</sup> *Ibid*, 18 November, 1938, p 24.

<sup>14</sup> NAS, CMB 1/6, *CMB Minutes*, 21 February, 1941, Vol 25, p 31; NAS, CMB 1/6, *CMB Minutes*, 24 March, 1939, Vol 24, p 9.

<sup>15</sup> *Oral testimony*. For details of the oral interviews conducted in relation to this research, see Appendix 4. LR, 29 [94].

<sup>16</sup> NAS, CMB 1/6, *CMB Minutes*, 24 March, 1939, Vol 24, p 9.

<sup>17</sup> G Cumberlege, *Maternity in Great Britain*, (London: Oxford University Press, 1948), p 68.

when she was in labour. A Hebridean midwife said, ‘the first visit – they would say “there’s another one on the way but don’t tell the doctor”. I would say, “but I must tell the doctor”. And the doctor went after you notified him.’<sup>18</sup>

The Board agreed in principle with Dr Davidson’s statement. However it argued that there would be a problem if LA maternity scheme midwives heard they were officially considered to be maternity nurses. This would mean that all midwives working under such schemes were outwith much of the jurisdiction of the Board. Midwives could say they were working as maternity nurses under the supervision and direction of a doctor as in Rule D1 and therefore only subject to a few Rules of the CMB. The Board asked the MOH for Greenock to distinguish between LA Maternity Scheme and non-scheme cases in his annual report. In non-scheme cases, that is private cases, a midwife working with a doctor was considered for the purposes of the Act to be working as a maternity nurse and was, at the time, not subject to all the Rules of the Board. It also set in motion an amendment to the Rules regarding this issue and clarifying the situation. Thus, in 1946 an amendment to Rule D1 approved by the DHS said ‘A midwife who acts under a Maternity Services Scheme of a LA as provided for under the Maternity Services (Scotland) Act 1937 is regarded as a midwife and as such is subject to all the Rules of the Board whether or not a doctor is present at the confinement’.<sup>19</sup>

Further clarification was required the following year in the Board Minutes’ first mention of the National Health Services (Scotland) Act 1947, implemented across Britain on 5 July 1948. Sir Alexander MacGregor, MOH for Glasgow and a CMB member, pointed out that under this Act the Board would have very little jurisdiction over a

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<sup>18</sup> LR, 23 [99].

<sup>19</sup> CMB Rules, 1940, D 1, p 29; NAS, CMB 1/7, CMB Minutes, 25 February, 1944, Appendix, p 2; NAS,

woman (certified as a midwife), acting as a maternity nurse. He suggested that when a certified midwife was acting as a maternity nurse under the NHS Act she should be regarded as a midwife and the Board agreed to amend the previous change in the Rules to reflect this.<sup>20</sup>

To summarise, after the changes in the Rules were put into effect in 1948 firstly, a certified midwife who worked within the LA maternity schemes and the NHS, was classed as a practising midwife whether practising with a doctor or not and was subject to all of the CMB Rules. Secondly, a certified midwife, not working within the LA maternity scheme or the NHS, for example, privately, and if under the direct supervision of a doctor, was said to be working as a maternity nurse. Thirdly, a woman who had passed Part 1 of the CMB examinations could practise as a maternity nurse, under the supervision of a medical practitioner. She was not permitted to deliver babies except in an emergency but was subject to certain CMB Rules.<sup>21</sup> Lastly, a woman, registered as a general nurse could act as a maternity nurse under the supervision of a medical practitioner. Because she had not passed any CMB examinations, the CMB had no jurisdiction over her. The 1948 CMB Rules added: ‘if a midwife is in doubt she should regard herself as acting as a **midwife** and not as a maternity nurse’.<sup>22</sup>

### Teachers of midwifery

As we saw above in Chapter 2, after the 1915 Midwives (Scotland) Act, certain institutions in Scotland were approved by the Board as teaching institutions for the

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CMB 1/7, CMB Minutes, 27 February, 1945, p 2; NAS, CMB 1/7, CMB Minutes, 31 January, 1946, p 1.

<sup>20</sup> NAS, CMB 1/7, CMB Minutes, 20 November, 1947, p 2; CMB Rules, 1948, D1, p 34.

<sup>21</sup> NAS, CMB, 1/7, CMB Minutes, 20 November, 1947, p 3. These Rules were D 2,4,5,6,8,11,12 and 36.

<sup>22</sup> CMB Rules, 1948, Rules D 1, p 34.

purpose of running courses in midwifery. Those who taught pupil midwives were lecturers and teachers: lecturers were medical practitioners with sufficient experience and expertise to be approved by the Board for this purpose; teachers were experienced midwives approved by the Board. To begin with there was no formal teacher training course available for midwives who wanted to teach. A qualification in teaching developed during the late 1930s: the Midwife Teachers' Diploma (MTD). Up until the mid-1930s, midwives wishing for recognition as teachers of midwives in Scotland had to belong to an approved training institution and apply with references of good practice and ability to the Board. The Board upgraded this after the 1937 Maternity Services (Scotland) Act to a basic requirement of at least three years' midwifery practice and satisfactory evidence of teaching competence. The midwife also had to be either on the staff of, or working in association with, an approved training institution, must have attended at least sixty cases in the previous year and had to provide adequate accommodation and facilities for her pupils. These stipulations became particularly relevant as district midwifery changed.<sup>23</sup> The number of hospital births increased with a corresponding drop in available district 'cases' for pupil midwives within a training institution catchment area. Thus the CMB waived its Rule about teaching midwives being attached to a training institution and, in the late 1940s asked other midwives as well to apply to teach pupils. Most were accepted with a few exceptions where the midwife involved had not practised for at least three years.<sup>24</sup>

The CMB Rule book for 1947 indicated a change in the Board's approval of teachers of midwifery and excluded from teaching any midwife (whether MTD or not)

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<sup>23</sup> CMB Rules, 1940, Rules C 21 (a), (b) and (c), p 20; This issue is discussed later in Chapter 4, p 136.

<sup>24</sup> NAS, CMB 1/7, CMB Minutes, 23 February, 1949, p 4; .NAS, CMB 1/7, CMB Minutes, 26 August,

who was not also a registered nurse.<sup>25</sup> The RCM in 1951 asked the CMB to reconsider for midwives with the MTD who were not registered nurses, but this Rule did not change during the time of the CMB's existence.<sup>26</sup> As far as midwives without the MTD were concerned, in 1968 the Rules changed again, approving once more midwives who were not nurse trained to teach pupil midwives. Ironically, 1968 was also the year when the CMB stopped midwifery training for non-nurses in Scotland.<sup>27</sup>

The CMB was slow to establish a midwife teaching course in Scotland. In 1926 in England, the Midwives' Institute (the forerunner of the College of Midwives in England), started courses towards a Midwife Teacher's Certificate.<sup>28</sup> Further courses (in collaboration with the College of Nursing in England) developed when the 1936 Midwives Act for England and Wales made statutory provision for a midwife teaching qualification: the MTD.<sup>29</sup> The Scottish Board of the College of Nursing initiated plans in 1936 with the CMB for a similar course. After an enthusiastic start, the Minutes say no more on this issue until late 1937 when the Board admitted to the Scottish Board of the College of Nursing that it was not nearly ready to put any plans into operation.<sup>30</sup>

Two circumstances appear to have galvanised the Board into action. Miss Jean P Ferlie, Matron of the Edinburgh Royal Maternity and Simpson Memorial Hospital, the 'old Simpson', wrote to the CMB in December 1937 with a suggested syllabus for the

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1948, p 1.

<sup>25</sup> CMB Rules, 1947, Rules B 28, p 22.

<sup>26</sup> NAS, CMB 1/7, CMB Minutes, 31 May, 1951, p 1; RCM Scottish Council Minutes, 5 May, 1951.

<sup>27</sup> CMB Rules, 1968, pp 5 and 18.

<sup>28</sup> Towler, J, and Bramall, J, Midwives in History and Society, (London: Croom Helm, 1986), p 207.

<sup>29</sup> Ibid, p 227.

<sup>30</sup> NAS, CMB 1/5, CMB Minutes, 28 February, 1936, Vol 20, p 38; NAS, CMB 1/5, CMB Minutes, 27 March, 1936, Vol 21, p 8; NAS, CMB 1/5, CMB Minutes, 24 April, 1936, Vol 21, p 9; NAS, CMB 1/5, CMB Minutes, 28 October, 1937, Vol 22, p 23; Board Minutes do not explain why the Scottish Board of the College of Nursing was involved here. In England, the College of Midwives initially organised the course and then in collaboration with the College of Nursing. The SMA probably did not have the

MTD.<sup>31</sup> Miss Ferlie was well known for her leadership qualities and work in midwifery. Also, she was enthusiastically supported by the Midwifery Tutor at the Simpson, Mrs Margaret Myles, whose text-books for midwives are legendary.<sup>32</sup> It is likely that Miss Ferlie's letter was designed to persuade Board members to expedite matters. As a further incentive, the 1937 Maternity Services (Scotland) Act gave the CMB the power to grant the MTD.<sup>33</sup> Thus activated, the Board got the first course underway in 1938, and approved the next, run by the now 'Royal' College of Nursing (RCN) in 1942-1943.<sup>34</sup> However, although by 1953 forty-six midwives in Scotland had achieved the MTD, the courses were sporadic and this was a slow start for the MTD in Scotland compared to the course in Kingston-upon-Thames which ran regularly with CMB (E&W) approval from its outset.<sup>35</sup>

The MTD course in Scotland remained while the Board existed. It developed from a part-time day-release course into a full-time nine month course run by the RCM Scottish Council, in Glasgow in 1966, in Edinburgh in 1967 with further plans for a Clinical Teachers' Instruction Course.<sup>36</sup> When financial constraints prevented the RCM from continuing, the Board negotiated places for midwives at Jordanhill College of

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resources to run the MTD course.

<sup>31</sup> NAS, CMB 1/5, CMB Minutes, 17 December, 1937, Vol 22, p 25.

<sup>32</sup> E F Catford, The Royal Infirmary of Edinburgh 1929-1979, (Edinburgh: Scottish Academic Press, 1984), pp 209-210, and, S Bramley, and M Turner, 'Obituary: Mrs Margaret Fraser Myles 1892-1988', in Midwifery, 4, 1988, pp 93-94. The term 'tutor' came into use about this time, possibly to differentiate between 'teachers' who in this context were midwives without the MTD, and midwives who had passed the MTD.

<sup>33</sup> 1937 Maternity Services (Scotland) Act, [I Edw 8 & I Geo 6 Ch 30], 8, (4), (a).

<sup>34</sup> NAS, CMB 1/5, CMB Minutes, 25 February 1938, Vol 22, p 32; NAS, CMB 1/6, CMB Minutes, 20 February, 1942, Vol 26, p 17; Ibid, 2 April, 1942, p 31; Ibid, 26 February, 1943, p 36; NAS, CMB 1/7, CMB Minutes, 13 April, 1943, p 3.

<sup>35</sup> NAS, CMB 1/7, CMB Minutes, 25 July, 1950, p 1; NAS, CMB 1/7, CMB Minutes, 20 November, 1947, p 3; NAS, CMB 1/7, CMB Minutes, 26 February, 1953, 'Chairman's Review of the Board's Progress since 1915', p 4.

<sup>36</sup> CMB Report, 31 March, 1967, p 2.

Education on a course for Nurse Tutors which began in October 1971.<sup>37</sup> This course, with specific midwifery support and supervision, emphasising teaching methods and educational subjects, proved to be a success and a welcome innovation from the more traditional MTD. It remained as the accepted course for the MTD until well into the 1980s when more midwife teachers were educated to degree level.

Thus the establishment of a MTD in Scotland, however slowly it happened, was part of a bid to improve midwifery practice and education and make midwifery an attractive profession that intelligent women would want to be a part of. This was particularly important during World War II and afterwards when the shortage of midwives reached unprecedented levels.

## **World War II: the shortage of midwives**

World War II had a major impact on the recruitment and retention of midwives both during and after the war. The Government anticipated problems with this and instituted a form of National Service just before the war began, in an effort to keep up the supply of midwives in Britain.<sup>38</sup> This, to begin with, was voluntary, but registration became compulsory in 1943 with the Nurses and Midwives (Registration for Employment) Order. Midwives who volunteered were prepared to commit themselves to midwifery for the duration of the war. Initially, ninety-one per cent of volunteers for National Service were midwife-only trained.<sup>39</sup> By 1939 the majority of midwives were also registered nurses. It

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<sup>37</sup> CMB Report, 31 March, 1971, p 2.

<sup>38</sup> J M Munro Kerr, R W Johnstone, M H Phillips, Historical Review of British Obstetrics and Gynaecology 1800-1950 (Edinburgh and London: E and S Livingstone Ltd., 1954), p 345.

<sup>39</sup> This was not National Service in the accepted military sense. Rather, it was a form of service to the nation, where, in this instance, midwives would commit themselves to working as midwives for the duration of the war. NAS, CMB 1/6, CMB Minutes, 17 February 1939, Vol 23, p 35; NAS, CMB 1/6, CMB Minutes, 24 March, 1939, Vol 24, p 8; Ibid, 5 May, 1939, p 12; Ibid, 21 July, 1939, p 23.

follows therefore, that many midwives who were also nurses did not want to act as midwives during the war years. It is possible that those who were nurse-trained felt they could better serve the war effort if they went into active service as nurses.<sup>40</sup> However Jean Woods, pupil midwife in Glasgow in 1943 suggested a less altruistic reason. She said, 'You see, everybody wanted to go into the army or into the Services because you were a lieutenant, two pips up on your shoulder with a batman between two of you – well it was enticing'<sup>41</sup>.

While the shortage of midwives became acute there was a source of help if the Government had been more willing to accept it: medically qualified women who were refugees from other countries and willing to train as midwives. In the early 1930s as Hitler's power grew, many people in danger of persecution from the Nazi movement, left Germany to take refuge in Western European and other countries. The influx of refugees to Britain stayed at a low level until 1938 when demands from British pressure groups facilitated the immigration of a further 40,000 refugees. Many of these were known as 'transmigrants' as they had to move on when they received visas for their first choice of destination. However, for most, the outbreak of World War II foiled these plans and they had to stay in Britain for the duration. Thus, about 80,000 refugees from Germany, Austria and Czechoslovakia lived in Britain during the war and afterwards.<sup>42</sup>

The British Government was reluctant to allow refugees, medically qualified in Germany, to practise in Britain but agreed in the 1930s to accept 500 doctors, reduced to fifty under pressure from the British Medical Association (BMA). Thus, many German doctors entered Britain and, despite the shortage of doctors, had no prospect of

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<sup>40</sup> B McBryde, *A Nurse's War*, (London: The Hogarth Press, 1986), p 33.

<sup>41</sup> LR, 45 [128].



employment. Some applied to go to medical schools in Britain but then had to find money for their fees in a country where refugees were not routinely given work permits. Some found work, but well below their capabilities: 'a surgeon secretly washed corpses in a morgue, a radiologist repaired radios and a bacteriologist peddled baking powder'. They found the problems of adjustment almost more than they could bear.<sup>43</sup>

Some women doctors from middle European countries applied for midwifery training in Britain. This too had problems, not least of which was the slowness of the Home Office to give its approval and of the Board to make decisions. By 1939 the CMB (E&W) had registered about thirty-five women refugees, most of whom had medical qualifications, as pupil midwives for the two year course.<sup>44</sup> In the same year the Board received and accepted three similar applications from medical practitioners to train as midwives in Scotland.<sup>45</sup> Official Home Office agreement with the midwives sub-committee of the Refugees' Joint Consultative Committee (RJCC) to allow about 200 refugees into Britain for training eventually came in September 1939.<sup>46</sup> Before the Board finally decided how many refugees it could accept for training in Scotland, events forced its hand. In late 1939, the management at training institutions in Greenock, Govan and GRMH accepted without permission from the Board, ten women refugees from Germany, Czechoslovakia and Austria to do midwifery training. Faced with this *fait accompli*, the Board agreed to accept these applicants provided all their certificates and papers were satisfactory. At the same time, the CMB at last came to a decision that no

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<sup>42</sup> M. Berghahn, *Continental Britons*, (Oxford: Berg Publishers Limited, 1988), p 75.

<sup>43</sup> *Ibid*, pp 83-87.

<sup>44</sup> NAS, CMB 1/6, *CMB Minutes*, 24 March, 1939, Vol 24, p 8.

<sup>45</sup> NAS, CMB 1/6, *CMB Minutes*, 9 June, 1939, Vol 24, p 17; *Ibid*, 21 July, 1939, p 23; *Ibid*, 20 December, 1939, p 31; *Ibid*, 5 May, 1939, pp 11 and 12.

<sup>46</sup> NAS, CMB 1/6, *CMB Minutes*, 23 February, 1940, Vol 24, p 39.

more than six refugees should be accepted as pupil midwives in any one year in Scotland.<sup>47</sup>

Refugees were prepared to work for less money than locals. In January 1941, three refugees applied to the Burgh Maternity Hospital, Kilmarnock for midwifery training. When the Board investigated why so many refugees were attracted to one small hospital, it discovered that the refugees found they had an opportunity because the hospital salary was so low that no-one from home would apply. One of those candidates was able to continue training.<sup>48</sup>

The Home Office and BMA policy towards medically trained refugees appears to have been very strict. 'In spite of a shortage of doctors in some parts of Britain, only 460 foreign practitioners of all nationalities had Home Office permits to practise in July 1940.'<sup>49</sup> There was also a shortage of midwives and it would have aided the situation if more refugee doctors had been allowed to train as midwives. The CMB in Scotland accepted a disproportionately low number of the two hundred refugees allowed to train in Britain. This decision could suggest that the Board put a high priority on protecting the material interests of the existing midwives in Scotland rather than providing services. However it could also suggest that the Board allowed its distrust of anyone who came from beyond Britain to prevail, even though it might be to the detriment of the midwifery service.

The war affected midwifery staffing levels and also training prospects. The Board decided to keep a close watch on the trend of numbers of practising midwives during the

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<sup>47</sup> Ibid, 29 September, 1939, p 26; Ibid, 20 December, 1939, p 33. At this point the current total appears to have been thirteen refugee pupil midwives in Scotland.

<sup>48</sup> NAS, CMB 1/6, CMB Minutes, 17 January, 1941, Vol 25, p 21.

<sup>49</sup> Berghahn, Comtinentals Britons, p 85.

war years and after.<sup>50</sup> This included examining on a quarterly basis, details of the number of pupil midwives in training in a given institution, the prospective number waiting and the number of vacancies for training in each institution.<sup>51</sup> This was subject to change at short notice as many pupil midwives were members of the Territorial Army Nursing Service. Also, as they could be called up at any moment, they worried that this would affect their training on return to civilian life. This issue led the Board to waive for the duration of the war, the current Rule which stipulated possible extra training for pupils who did not begin Part 2 within six months of passing Part 1.<sup>52</sup>

While some women left midwifery for the Armed Forces, there were still pupil midwives aiming to reach the end of Part 2 albeit with difficulty. For instance, in 1941, conditions in Greenock as a result of enemy action, left pupil midwives with difficulty getting enough district cases. This was possibly due to evacuation of mothers or that some women chose hospital as a safe haven from the blitz, although a pupil midwife at Rottenrow seemed to contradict this when she said, 'When the bombers went over the mothers and babies were put under the beds to give them even a little protection'.<sup>53</sup> In the Greenock case the Board allowed pupil midwives, for the time of the emergency, to have twenty-five indoor and five outdoor cases instead of twenty and ten.<sup>54</sup>

By April 1942 there was an 'acute shortage of trained nurses and midwives throughout Scotland' with Matrons of several maternity homes contemplating discontinuing some or all of their maternity work for lack of staff.<sup>55</sup> This was

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<sup>50</sup> NAS, CMB 1/6, CMB Minutes, 29 September, 1939, Vol 24, p 25.

<sup>51</sup> Ibid, 20 December, 1939, p 30.

<sup>52</sup> Ibid, 29 September, 1939, p 26; CMB Rules, 1940, Rule C 9, p 16.

<sup>53</sup> LR, 3 [2].

<sup>54</sup> NAS, CMB 1/6, CMB Minutes, 18 July, 1941, Vol 26, p 6. For further discussion of the effects of World War II on the trend towards hospital for birth see Chapter 7 p 237.

<sup>55</sup> NAS, CMB 1/6, CMB Minutes, 2 April, 1942, Vol 26, p 31.

exacerbated by the birth-rate, rising in the late 1930s to ‘unprecedentedly high’ levels, and continuing to rise in the 1940s.<sup>56</sup> At the Board’s behest the DHS and the Ministry of Health negotiated with the Army Council who agreed to exempt from calling up to the Army Nursing Services, practising midwives already waiting to be conscripted, and to refuse any new applications from practising midwives to join any of the Armed Services.<sup>57</sup> In addition, The Nurses and Midwives (Registration for Employment) Order, 1943 required all nurses and midwives to register with the Ministry of Labour by 10 April 1943 unless they had been compulsorily retired or had their names struck off the Roll. Those who failed to register were liable to a maximum fine of £100, imprisonment or both.<sup>58</sup> Retired midwives and nurses were not compelled to return to work, but publication of this Registration Order indicated a high level of persuasion. In addition, the Ministry of Labour and National Service decided that newly qualified midwives had to practise for a year and, as a temporary measure for the next six months, no practising midwife could take up employment other than in midwifery. Jean Woods said, ‘They were actually having to take midwives out of the QAs to staff hospitals until they had enough newly qualified ones’.<sup>59</sup> The new regulations did not go unchallenged and some pupil midwives protested against the compulsory one year’s practice after enrolment. However, this requirement did not apply to pupil midwives who had only done Part 1. They could interrupt their training but only at that point because of the potential wastage of training places.

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<sup>56</sup> Towler and Bramall, *Midwives in History and Society*, p 231.

<sup>57</sup> NAS, CMB 1/6, *CMB Minutes*, 2 April, 1942, Vol 26, p 31; *Ibid*, 20 November, 1942, p 32.

<sup>58</sup> ‘Editorial’, *Nursing Times*, 10 April, 1943, pp 229-230.

<sup>59</sup> LR, 45 [128].

The shortage of both midwives and nurses continued. In 1943 there was no evidence that a problem with recruitment of pupil midwives existed.<sup>60</sup> This situation changed as midwives who were nurses found that the new regulations prevented them from going on active service. By 1945 the Board expressed its concern to the DHS that too few women were entering midwifery training to meet the staffing standards of maternity hospitals and training institutions.<sup>61</sup> Thus the war's impact on midwifery was: to exacerbate the already poor retention of midwives who were nurse-trained until the 1943 regulation prevented this; and, from 1943, to reduce recruitment of pupil midwives as nurses saw if they did midwifery, they were unlikely to be allowed to return to nursing for the duration of the war.

### **Post war problems**

The end of the war exacerbated the midwifery staffing problem. According to Towler and Bramall the birth rate reached its peak in 1946 thus making critical the shortage of midwives. However, there were other reasons: many midwives stopped practising after marriage and others returned to general nursing after midwife training; some midwives, recalled during the war years, went back into retirement.<sup>62</sup> Another important element was the increase in time required for their work. The 1939 CMB Rules lengthened the lying-in period from ten to fourteen days.<sup>63</sup> Thus, midwives had to make more time-consuming postnatal visits. Also, statutory training for midwives and pupil midwives in

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<sup>60</sup> NAS, CMB 1/7, CMB Minutes, 8 October, 1943, p 1.

<sup>61</sup> NAS, CMB 1/7, CMB Minutes, 27 February, 1945, p 4.

<sup>62</sup> Towler and Bramall, Midwives in History and Society, p 233.

<sup>63</sup> CMB Rules, 1939, Rules D 24, p 37.

the use of inhalational analgesia during childbirth started on 1 July 1946, increasing the time a midwife spent with a labouring woman.<sup>64</sup>

Government bodies and the Boards tried different ways of handling the problem of the shortage of midwives across Britain. This included a Government recruiting pamphlet sent out in 1946<sup>65</sup> and a change in CMB Rules relaxing the requirements of Rules C when employing 'foreign trained' midwives.<sup>66</sup> Thus, the CMBs could enrol midwives from other countries who supplied appropriate references and completed the application form for 'Midwives of Alien Nationality for Midwifery Employment in Great Britain'.<sup>67</sup>

Yet, recruiting midwives and nurses from furth of Scotland could not solve everything. Immediately post-war a new two year enrolment course for nurses was established. To begin with nurses with enough war-time experience were enrolled without examination. Margaret Crombie was one of them and she recalled, 'When the war finished anybody who had a certain grade of nurse training...got a new certificate...Enrolled Nurse. So I was given one when I left because of the experience that I had.'<sup>68</sup> Enrolled nurses in Scotland who wanted to be midwives had to do the two year course to begin with. The CMB altered this Rule to eighteen months in 1961.<sup>69</sup>

In 1947 a Working Party, chaired by Baroness Stocks, jointly appointed by the Ministry of Health, the Ministry of Labour and National Service and the DHS, met to

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<sup>64</sup> NAS, CMB 1/7, CMB Minutes, 28 February, 1946, p 3.

<sup>65</sup> NAS, CMB 1/7, CMB Minutes, 31 January, 1946, p 1.

<sup>66</sup> NAS, CMB 1/7, CMB Minutes, 31 October, 1946, p 2. Rules C dealt with regulating the course of training, the conduct of examinations, the remuneration of examiners and the issue of certificates.

<sup>67</sup> RCS Ed 13/1/4, (CMB), letter from Secretary CMB (E&W) to Secretary CMB dated 31 October, 1946, and copy of application form. RCS Ed, 13/1/1, (CMB), Reference translated from Norwegian; NAS, CMB 1/7, CMB Minutes, 31 October, 1946, p 1

<sup>68</sup> LR, 37 [114].

<sup>69</sup> NAS, CMB 1/8, CMB Minutes, 15 June, 1961, p 2; an Enrolled Nurse in Scotland was equivalent to a

consider the UK-wide problems and shortage of midwifery in the UK. This included examination of: recruitment and training, the 'proper' duties of a midwife, inter-professional relationships and how best to minimise wastage.<sup>70</sup> The Working Party reported in 1949. A similar Working Party set up for the nursing profession, reported in 1948.<sup>71</sup>

In April 1949 the Board considered the Report of the Working Party on Midwives.<sup>72</sup> The Working Party saw conflict between GPs and midwives as a major problem. Since the start of the NHS, GPs 'were seriously encroaching on the midwife's function by taking over the antenatal care of patients ... in some cases midwives were becoming little more than maternity nurses'. The Working Party emphasised the complementary nature of the work of midwives and GPs but recommended the retention of the role of the midwife as an expert in all aspects of normal childbearing.<sup>73</sup>

The Working Party also paid tribute to the midwife who was not nurse-trained. Direct entry midwives were disadvantaged as far as promotion went and the Working Party stressed the injustice of this. A greater proportion of direct entry midwives than those who were nurse-trained practised midwifery, and they appeared to be highly motivated.<sup>74</sup> In contrast, some nurses took midwifery training as a means to promotion in

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State Enrolled Nurse in England.

<sup>70</sup> Ministry of Health, DHS, Ministry of Labour and National Service, Report of the Working Party on Midwives, (London: HMSO, 1949), Introduction, para 1; Kerr, Johnstone and Phillips, Historical Review, p 345.

<sup>71</sup> R Peters and J Kinnaid, Health Services Administration, (Edinburgh: E.& S. Livingstone Ltd, 1965), p 316. The Working Party on the Recruitment and Training of Nurses recommended that midwifery should be amalgamated with the general nurses training programme.

<sup>72</sup> NAS, CMB 1/7, CMB Minutes, 28 April, 1949, p 3.

<sup>73</sup> Towler and Bramall, Midwives in History and Society, p 234; Working Party on Midwives, paras 101 and 102.

<sup>74</sup> Ibid, para 116.

nursing. This was expensive in terms of training costs, places and time, and only partly solved by two-part midwifery training.<sup>75</sup>

Furthermore, the Working Party highlighted the differences in the roles of the midwife and the nurse, stressing that the midwife 'was a practitioner in her own right' working with women who were undergoing an 'important but normal period in their lives'. By contrast, nurses worked with doctors, focussing on caring for the sick. However, the Working Party recognised the need for midwives to have a thorough grounding in nursing techniques and explored the future possibility of nurses and midwives sharing a basic training which would not carry a qualification, before specialisation in midwifery or a branch of nursing. Thus, the Working Party's Report marked the beginning of a move to bring students of differing disciplines together.<sup>76</sup> Finally, the Working Party recommended a single period of midwifery training which later came to fruition.<sup>77</sup>

The Board gave general approval to the conclusions of the Working Party. They particularly highlighted the fact that non-nurses should not be prevented from training as midwives.<sup>78</sup> The Board endorsed the distinction made between midwifery and nursing,

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<sup>75</sup> *Ibid*, paras 119-130

<sup>76</sup> *Ibid*, para 111-118; The 1972 Briggs Report made similar recommendations; Towards the end of the twentieth century, shared learning became more usual within universities bringing students of differing disciplines together and harnessing resources.

<sup>77</sup> Towler and Bramall, *Midwives in History and Society*, p 235; Kerr, Johnstone and Phillips, *Historical Review*, p 346.

<sup>78</sup> A few years after this, in Professor R Johnstone's valedictory address, he implied that one of the marks of progress of midwifery in Scotland was the fact that 'there has been a noticeable drop in the number of untrained women applying for training...and a correspondingly great increase in the number of general-trained nurses seeking to round off their practical training by studying midwifery': NAS, CMB 1/7, *CMB Minutes*, 26 February, 1953, p 3.



and in line with the Report, stated that the CMBs 'should remain completely independent of the General Nursing Councils'.<sup>79</sup>

### **'Gas and air' and the Minnitt apparatus**

While the Working Party considered midwives and their inter-professional relationships, one facet of the relationship between midwives and GPs underwent a significant change in the late 1940s: the administration of pain relief. Until the late 1940s the role of the midwife in Scotland in the use of inhalational analgesia in childbirth was minimal; from 1946 midwives could administer it. The CMB was central to this change.

Up until the 1930s the only inhalational analgesia in relatively regular use in childbirth was chloroform and its use was restricted to medical practitioners. This meant that mothers receiving chloroform for childbirth purposes at that time were those who could afford a doctor.<sup>80</sup> Medical practitioners experimented with ether and nitrous oxide as analgesics in the mid-nineteenth century, but it was not until 1932 that pressure from bodies like the National Birthday Trust stimulated the design of an apparatus for administering nitrous oxide and air, known colloquially as 'gas and air', to mothers in childbirth.<sup>81</sup>

The idea was that a form of inhalational analgesia should be available for midwives to use on their own responsibility.<sup>82</sup> Dr R J Minnitt of the Liverpool Maternity Hospital designed the apparatus encased in a portable wooden box to deliver nitrous

<sup>79</sup> NAS, CMB 1/7, CMB Minutes, 28 April, 1949, p 3; Working Party on Midwives, para, 291.

<sup>80</sup> Cumberlege, Maternity in Great Britain, p 78.

<sup>81</sup> D Moir, Pain Relief in Labour, 5<sup>th</sup> ed, (Edinburgh: Churchill Livingstone, 1986) p 1; A S Williams, Women and Childbirth in the Twentieth Century (Stroud: Sutton Publishing, 1997), p 127-128: The National Birthday Trust responded to mothers who contacted it because of their fear of pain in childbirth.

<sup>82</sup> Cumberlege, Maternity in Great Britain, p 78.

oxide and air in original concentrations of forty-five percent nitrous oxide and fifty-five per cent air, adapted later to a fifty-fifty mix.<sup>83</sup> By 1936 the CMB (E&W) allowed midwives there to administer gas and air to labouring mothers on their own responsibility provided they held a certificate of proficiency. However, due to the shortage of midwives, by 1946 only one in five midwives in England and Wales was qualified in this.<sup>84</sup> Furthermore, the weight of the apparatus was such that midwives could not carry it on their bicycles and although some authorities sent it in ambulances, these situations were few and far between.<sup>85</sup>

The negative attitude of GPs also appears to have been an important factor in delaying any widespread use of gas and air by midwives until after the war. As late as 1939 the BMA debated the issue at its annual meeting. Some doctors said 'they wanted to stop midwives controlling the midwifery of the country' and the meeting ended with a resolution stating the opposition of GPs to the idea of midwives using gas and air.<sup>86</sup> It is probable that a suitable method could have been developed many years earlier but the stimulus to produce it was lacking because of: the low standing of midwives; historical prejudice against women in childbirth receiving pain-relief; and the attitude of members of the medical profession.<sup>87</sup> The attitude of GPs particularly, was significant. According to Williams they were being squeezed out of midwifery: on one side, by pressure from obstetricians trying to consolidate their role as experts and to create a need for women to give birth in hospital; and, on the other, pressure from midwives (in England and Wales),

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<sup>83</sup> Williams, *Women and Childbirth in the Twentieth Century*, p 135.

<sup>84</sup> Cumberlege, *Maternity in Great Britain*, p 79.

<sup>85</sup> Towler and Bramall, *Midwives in History and Society*, p 237; *Working Party on Midwives*, para 105: the apparatus in the 1940s weighed 22 lbs.

<sup>86</sup> Williams, *Women and Childbirth in the Twentieth Century*, p 141.

<sup>87</sup> Cumberlege, *Maternity in Great Britain*, p 78.

who were increasing their share of home confinements helped by being allowed by the 1936 Midwives Act to use inhalational analgesia with the backing of public health officers.<sup>88</sup>

In Scotland, the situation was different. The 1937 Maternity Services (Scotland) Act provided for an anaesthetist to attend a woman in her home if necessary, for the administration of chloroform.<sup>89</sup> There was no mention in the Act that midwives should be allowed to administer inhalational analgesia.<sup>90</sup> If the influence of GPs in England delayed the use of gas and air in childbirth there, then with the strong tradition of GPs in midwifery in Scotland it is possible that GPs in Scotland were even more influential than their English counterparts.<sup>91</sup>

Midwives in Scotland were not allowed to use inhalational analgesia for pain relief in labour until 1946. The issue was aired in 1937 when the DHS asked the Ministry of Health about midwives' use of gas and air in England and whether there had been any opposition from the medical profession.<sup>92</sup> Only after this discussion, did the DHS consult the CMB. Around the same time Scottish midwifery training institutions started asking the Board about its policy on midwives and inhalational analgesia. As the Board had no current policy for this, it consulted the CMB (E&W), forwarded the information to training institutions in Scotland and contacted various training institutions in England to find out more about their courses.<sup>93</sup>

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<sup>88</sup> Williams, *Women and Childbirth in the Twentieth Century*, p 140.

<sup>89</sup> 1937 Maternity Services (Scotland) Act, 1, (2), (d).

<sup>90</sup> CMB Rules, 1948, Rules C, pp 31-33.

<sup>91</sup> Williams, *Women and Childbirth in the Twentieth Century*, p 141.

<sup>92</sup> Williams, *Women and Childbirth in the Twentieth Century*, p 140.

<sup>93</sup> NAS, CMB 1/6, *CMB Minutes*, 16 December, 1938, Vol 23, p 28; *Ibid*, 20 January, 1939, p 30; *Ibid*, 17 February, 1939, p 33

Thus, in the late 1930s, there was much discussion about this issue and a need for the CMB to make a decision. The Board learned about appropriate facilities available in training institutions in Scotland and received information from maternity hospitals in London, Manchester and Liverpool about CMB (E&W) approved instruction on inhalational analgesia. The approved course lasted four weeks ‘two of which had to be whole-time instruction’. It consisted of ‘lecture demonstrations’ given by a specialist anaesthetist and the administration under supervision of nitrous oxide and air via the Minnitt apparatus to at least twenty labouring mothers.<sup>94</sup> The CMB, now fully informed, said ‘no’ to the idea of midwives in Scotland administering inhalational analgesia. It pointed out to the DHS that the 1937 Maternity Services (Scotland) Act provided for an anaesthetist to be present for every woman in childbirth if necessary. The Board decided to wait and see what demand there was for the presence of anaesthetists before allowing midwives to administer gas and air by the Minnitt apparatus.<sup>95</sup>

The Board’s decision did not appear to take into account the distinction between the use of the two substances: chloroform in labour given by an anaesthetist was to anaesthetise mothers having difficult deliveries, while gas and air was used to alleviate the mother’s pain in labour. When the DHS asked the Board in 1941 to reconsider, the DHS’ argument centred round medical practitioners being called up and the need to give greater responsibility to midwives. However, the Board would not alter its decision, stating that some medical practitioners might consider this as a retrograde step. Also, more change would be premature as the recommendations of the 1937 Maternity Services (Scotland) Act were still settling down. Furthermore, the Board pointed out to the DHS

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<sup>94</sup> NAS, CMB 1/6, CMB Minutes, 24 March, 1939, Vol 24, p 7;

<sup>95</sup> Ibid, 9 June, 1939, p 16.

this time, that the analgesia procured from the Minnitt apparatus was only analgesia and not anaesthesia. Therefore its use could not be construed as replacing doctors who might be called up.<sup>96</sup>

When the war ended, the Board eventually succumbed to pressure and changed its Rules. The CMB (E&W) decided to include the administration of inhalational analgesia in Part 2 midwifery training with effect from 1 July 1946, and the DHS, GRMH, the QIDNS and the CMB Eire sent the Board letters in favour of this. Thus, to ensure the maintenance of Scottish midwifery status and qualifications, the Board agreed to give the same opportunity to midwives in Scotland.<sup>97</sup> The first requirement was for midwives who were to supervise and teach on the courses to become proficient themselves, and the Board encouraged training institutions to draw up arrangements for this. Before long, the course became an integral part of midwifery training.<sup>98</sup>

Once the Board accepted that midwives should administer inhalational analgesia, the nature of the analgesia became the issue. Trilene, the trade name for Trichlorethylene, is another form of inhalational analgesia. Although faster acting than gas and air, inexpensive and its apparatus more portable than the Minnitt machine, Trilene was not CMB-approved in the late 1940s for midwives' use because of its accumulative effect.<sup>99</sup> However, during the following six years there was a high level of discussion and negotiation on the issue, between the Board, medical practitioners, the Medical Research Council Committee on Analgesia, inter-Governmental departments and the CMB

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<sup>96</sup> NAS, CMB 1/6, CMB Minutes, 17 January 1941, Vol 25, p 20. This time the Board used the anaesthesia/analgesia argument when it suited it to do so.

<sup>97</sup> NAS, CMB 1/7, CMB Minutes, 31 January 1946, p 2; NAS, CMB 1/7, CMB Minutes, 28 February, 1946, p 2.

<sup>98</sup> Ibid, p 3; NAS, CMB 1/7, CMB Minutes, 26 August, 1948, p 2.

<sup>99</sup> Moir, Pain Relief in Labour, p 82; The Board also approved the Jecta gas and air apparatus in 1949. This was similar to the Minnitt apparatus in that they both delivered a 50:50 nitrous oxide and air mixture

(E&W).<sup>100</sup> In 1955, while gas and air was still in widespread use, the Board agreed to amend the Rules in favour of Trilene although midwives using it had to undergo further instruction.<sup>101</sup> When discussing this issue at a later date, Donald Moir, a consultant anaesthetist and author of a standard text-book on pain-relief in labour, saw informed use of Trilene with an approved inhaler as quite acceptable.<sup>102</sup> In 1970 the CMB withdrew its approval of nitrous oxide and air administered by the Minnitt apparatus, probably because of the development of the safer fifty-fifty mixture of nitrous oxide and oxygen given by the still widely used Entonox apparatus.<sup>103</sup> However, Trilene and its inhalers continued to be officially sanctioned for midwives to use until the National Boards for Nursing, Midwifery and Health Visiting withdrew their approval in 1984 because of the widespread use of the Entonox apparatus.<sup>104</sup>

The CMB's late and reluctant approval for midwives to use inhalational analgesia reflected the influence of medical practitioners on the Board and the perceived threat of midwives extending their skills in this way.

### **The National Health Service (NHS) and its aftermath**

The NHS (Scotland) Act was passed in May 1947 and the NHS Acts were implemented across the UK on 5 July 1948. Health services were to be free to all as and when they were needed. Payment came from three sources: central funds, local rates and public

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<sup>100</sup> NAS, CMB 1/7, CMB Minutes, 28 April, 1949, p 1; NAS, CMB 1/7, CMB Minutes, 28 July, 1949, p 1; NAS, CMB 1/7, CMB Minutes, 28 April, 1949, p 3; NAS, CMB 1/7, CMB Minutes, 23 February, 1951, p 1; NAS, CMB 1/7, CMB Minutes, 6 June, 1952, p 2; NAS, CMB 1/7, CMB Minutes, 20 May, 1954, p 1; NAS, CMB 1/7, CMB Minutes, 18 November, 1954, p 1; NAS, CMB 1/7, CMB Minutes, 17 February, 1955, p 2; NAS, CMB 1/7, CMB Minutes, 10 November 1955, p 1.

<sup>101</sup> H P Tait, Trilene Analgesia, from notes belonging to Miss Isabel Duguid, MTD, July 1955.

<sup>102</sup> Moir, Pain Relief in Labour, p 84.

<sup>103</sup> Ibid, p 67.

<sup>104</sup> Ibid, p 66.

contributions to a national insurance scheme. Administratively, the NHS was originally designed to be run on a tripartite scheme. Firstly there were Regional Hospital Boards which in Scotland included the teaching hospitals. Secondly there were Executive Councils which administered general medical services, including dentistry and pharmacy. Under the NHS, GPs retained their status as independent contractors. Thirdly, there were Local Health Authorities responsible for providing maternity services, child welfare, midwifery, health visiting and home nursing. Maternity services provided by the local health authorities did not include hospitals.<sup>105</sup>

The new administrative structure fragmented maternity services, yet it did not directly alter the CMB or its responsibilities. The CMB Minutes make little explicit reference to the NHS, although in 1949 the CMB (E&W) voiced its concerns about the possibility of the midwife's role being diminished.<sup>106</sup> Also, as already mentioned, the Board discussed women practising as midwives or maternity nurses and the subsequent change of the CMB Rule to clarify this distinction after the implementation of the NHS.<sup>107</sup> Dr R Johnstone, in his valedictory address as Chairman in 1953, indicated his lack of enthusiasm for the administration of the new system which he called a 'trichotomy of a single biological function'. This fragmented maternity services and could lead to 'overlapping and confusion'. He also commented, 'this, however, does not directly affect the work of the Central Midwives Board and I need not dwell on it'.<sup>108</sup>

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<sup>105</sup> J Brotherston, 'The National Health Service in Scotland: 1948-1984', in G McLachlan, *Improving the Common Weal: Aspects of Scottish Health Services 1900-1984*, (Edinburgh: Edinburgh University Press, 1987) p 106.

<sup>106</sup> S Robinson, 'Maintaining the Independence of Midwives', in J Garcia, R Kilpatrick and M Richards, eds, *The Politics of Maternity Care*, (Oxford: Clarendon Press, 1990), p 73.

<sup>107</sup> See chapter 4, page 115.

<sup>108</sup> NAS, CMB, 1/7, *CMB Minutes*, 'Chairman's Review of the Board's Progress since 1915', 26 February 1953, pp 3-4.

Nevertheless, the NHS affected midwives and their practice. Firstly, pregnant women could now go to their GP free of charge to 'book'. Midwives were thus no longer the first point of contact. Secondly, GPs began to perform an increasing amount of antenatal care of pregnant women. As already mentioned, the Working Party on the Recruitment and Training of Midwives (1949) considered conflict between GPs and midwives as a major problem, exacerbated by the NHS and said that 'the take-over of antenatal care by GPs was an unwelcome trend that could destroy the midwifery service'.<sup>109</sup> Under the NHS, GPs received extra payment for undertaking maternity care and soon the proportion of GPs providing antenatal care rose quickly, thus further diminishing the midwife's role in this field.<sup>110</sup> Thirdly, the NHS brought problems from the point of view of safety and continuity of care. The Working Party reported that 'in some cases, midwives are not seeing patients until they go to deliver them'.<sup>111</sup> In addition, pupil midwives were not getting the opportunity to participate in antenatal care.<sup>112</sup> Fourthly, the NHS reinforced the existing trend towards hospital births. The new hospital boards' policy of centralisation of obstetric care matched an increasing demand for hospital births with a corresponding increase in medical involvement in normal maternity care.<sup>113</sup> From the mother's point of view it made economic sense and 'spared a family the extra expenses of giving birth at home, like food, bedclothes, sanitary towels, extra washing and adequate fuel'. Hospital births also gave many mothers a rest which

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<sup>109</sup> Towler and Bramall, *Midwives in History and Society*, p 234, Robinson, 'Maintaining the Independence of Midwives', p 72.

<sup>110</sup> S Robinson, 'Maintaining the Independence of Midwives', p 74.

<sup>111</sup> *Working Party on Midwives*, Postscript to Introduction, p viii.

<sup>112</sup> S Robinson, 'Maintaining the Independence of Midwives', p 73.

<sup>113</sup> H Tait, 'Maternity and Child Welfare', in G McLachlan, ed, *Improving the Common Weal*, (Edinburgh: Edinburgh University Press, 1987, p 420). S Robinson, 'Maintaining the Independence of Midwives', p 75.



they would not otherwise have had.<sup>114</sup> Nevertheless, although the number of hospital maternity beds was rising there were not enough to meet the rising demand.<sup>115</sup> Some mothers took it for granted that a hospital bed would be available and did not book. Mary McCaskill remembers the kind of situation in Glasgow.

At that time... it was just post-war and hospital beds weren't plentiful, a mother or a relative phoned in ...to say that Mrs A was in labour ...and could she go into hospital?... Now these telephonists... phoned round the hospitals... Rottenrow... Southern General, Stobhill, and if they couldn't obtain a bed they phoned to the night midwifery supervisor. And she got in touch with – say for instance it was me... I had to go out... as a municipal midwife... and... tell them that there was no hospital bed and the baby was going to be born in the house... [We] often got a hostile reception at first because a family was unprepared for this. They hadn't been prepared for a home confinement and they maybe didn't have a lot in the way of bed-linen and towels and even the minimum of baby clothes.<sup>116</sup>

Nevertheless, hospital births were on the increase and some midwives on the district began to feel very vulnerable and to wonder what would happen to them. Mary McCaskill continued,

Towards the end of that five years [1952] - the home deliveries had just sort of imperceptibly started to decline ... older midwives ... probably in their fifties were beginning to talk about – they didn't have so many bookings and they were wondering ... what was the future and what would they be used for... would they be maybe diversified into some other duties?'<sup>117</sup>

Thus the role of the midwife on the district diminished and very nearly disappeared and the move towards full hospitalisation of birth, gathering speed in the 1950s, was virtually unstoppable.<sup>118</sup>

As mentioned above, there were also problems of training pupil midwives according to Rules because the statutory ten district deliveries required for completion of

<sup>114</sup> Williams, *Women and Childbirth in the Twentieth Century*, p 200.

<sup>115</sup> See chapter 7, p 238.

<sup>116</sup> LR, 35 [27].

<sup>117</sup> *Ibid.*

<sup>118</sup> For further discussion on the change in place of birth, see chapter 7, p 235.

Part 2 became increasingly difficult to find. As institutional births gradually became more popular, the number of births on the district became correspondingly less. The Board had to decide what to do about training institutions which offered Part 2 training and yet could not provide the requisite number of mothers on the district for the pupils to deliver. The Board usually advised training institutions to continue offering Part 2 with the proviso that they should not take on more student midwives than they had district cases for.<sup>119</sup> This advice was repeated many times as training institutions in Scotland offering Part 2 tried to cope and some contemplated closing because of the shortage of district cases.<sup>120</sup>

The Board tried to consider the issue sympathetically. It even decided to accept a smaller number of domiciliary births where, due to changes in social conditions, training institutions had difficulty in providing the official number for Part 2 midwives.<sup>121</sup> Yet it was a long time before the Board agreed to make this reduction formal even though the issue recurred constantly through the 1950s reflecting the increasing trend of hospital births.<sup>122</sup> Finally, in September 1961 after receiving a formal complaint from the NE Regional Professional Committee on the Maternity Services about the issue, the Board set up an *ad hoc* committee to consider putting midwifery training on a more realistic basis and to discuss combining Parts 1 and 2 into a one year course.<sup>123</sup>

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<sup>119</sup> NAS, CMB 1/7, CMB Minutes, 28 February, 1947, p 2; NAS, CMB 1/7, CMB Minutes, 26 February, 1948, p 3; NAS, CMB 1/7, CMB Minutes, 20 November, 1947, p 3.

<sup>120</sup> NAS, CMB 1/7, CMB Minutes, 26 February, 1948, p 3.

<sup>121</sup> NAS, CMB 1/7, CMB Minutes, 20 November, 1947, p 3.

<sup>122</sup> NAS, CMB 1/7, CMB Minutes, 28 April, 1949, p 2; NAS, CMB 1/7, CMB Minutes, 28 July, 1949, p 1; NAS, CMB, 1/8, CMB Minutes, 11 May, 1961, p 1; NAS, CMB 1/7, CMB Minutes, 26 February, 1948, p 3.

<sup>123</sup> NAS, CMB, 1/8, CMB Minutes, p 1; Towler and Bramall, Midwives in History and Society, p 235.

While, as Professor Johnstone said, the NHS did not directly affect the work of the CMB, its effect fragmented maternity services, diminished the role of the midwife and speeded up hospitalisation and medicalisation of childbirth.

## **Conclusion**

This chapter has examined some aspects of the CMB's work from 1939-1959. During this time the CMB had to cope with what, at times must have been very difficult circumstances without precedents to guide members.

Changes in the Rules in 1939 extended midwifery training and divided the training into two parts in an attempt to leave Part 2, leading to full CMB certification, to those who were serious about practising as midwives. The 1939 Rules also led to the development of the MTD in Scotland which improved midwifery training, improved career prospects for some midwives, and included more midwives as CMB examiners. In 1947 the CMB changed and simplified the Rules reflecting what the Board saw as an improvement in general education as well as midwifery teaching and training. The new Rules also included those relating for the first time to the training of midwives in the use of nitrous oxide and air analgesia.<sup>124</sup>

There were also on-going issues with which the CMB had to deal. The shortage of midwives, exacerbated by events in World War II, increased post-war. In addition the Working Party on Midwifery showed problems between midwives and GPs which increased after 1948 and the implementation of the NHS Acts. The trend towards hospitalisation of childbirth affected both domiciliary and hospital midwifery practice,

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<sup>124</sup> CMB Rules, 1947, pp 31-33.

along with Part 2 midwifery training which depended on the pupil's achieving ten home births. Eventually the CMB bowed to pressure and reduced this number.

Thus, although in a number of respects midwives had more power than hitherto with improved education and more midwives on the Board, there remained limitations on their power from the top down. The Board was answerable to the DHS and all changes in Board Rules had to be approved by the DHS. In addition, as shown above, the Board had to change the Rules in response to external pressures. From the bottom up, the power of midwives was limited especially after the coming of the NHS. Within the NHS, they had the security of a salary, but because of their employee status, they relinquished what independence they might hitherto have had.<sup>125</sup> They also lost their mothers and babies to GPs and hospitals, their practical skills through lack of practice, and their decision-making skills because many decisions were made for them.<sup>126</sup> Thirdly, midwives were closely governed by a CMB which always had a statutory majority of medical practitioners.<sup>127</sup>

In the late 1940s and 1950s, the CMB acknowledged the improvement in the quality of midwifery in Scotland. It had numerous opportunities to give midwives more autonomy: when it upgraded the Rules in 1948; increased the number of midwives on the Board in 1953; and it could have used its influence with the DHS during the implementation of the NHS. The Board did not grasp these opportunities. The delay in the CMB's approval of the use of analgesia by midwives was symptomatic of the Board's desire to maintain control over midwives and their practice. The fact that until 1977 the

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<sup>125</sup> M Cronk, 'Midwifery: A Practitioner's View from Within the National Health Service', Midwife, Health Visitor and Community Nurse, Vol 26, No 3, March 1990, p 58.

<sup>126</sup> Ibid, pp 58-63.

<sup>127</sup> NAS, CMB 1/7, CMB Minutes, 14 November, 1951, p 1; NAS, CMB 1/7, CMB Minutes, 16 March.

Chairman of the CMB was always an obstetrician, sometimes retaining the chair for long periods could account for this failure. The attitude of both obstetricians and GPs in Scotland was highlighted by Margaret Kitson who commented

The tension I saw was with the medical profession who, for a very long time in Scotland, I think it wasn't so marked in England, but in Scotland, saw midwives as subservient and wanted to control midwifery. And it was only gradually that that changed.<sup>128</sup>

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1953, p 1.

<sup>128</sup> LR, 41 [120], CMB member 1973-1983.

## Chapter 5

### **The last decades of the CMB, 1960-1983:**

#### **changes in management, education, practice and statute**

During its last decades the Board had to handle issues which became increasingly threatening for the future of midwifery as a profession separate from nursing, for midwifery as a career, and for the credibility of the Board as a group. These issues centred round the re-organisation of management and education. The re-organisation of management included hospital and regional management, and the demise of the 'midwifery matron'. The Salmon Committee, commissioned by the Government and which reported in 1966, attempted to re-organise the management of senior nursing, including midwifery, in the UK. However in its wake came career problems for midwifery teachers and managers. In addition, the re-organisation of the NHS in 1974 brought problems associated with the integration of midwifery between the community and hospital which had an effect on the way midwives practised.

There were also changes in the relationship of the UK to Europe in this period which affected the work of the CMB and the required re-organisation of the education of midwives. These changes related to entry routes into midwifery – an old issue but one to which the European Economic Community (EEC) brought a new dimension. The Board became involved in the Midwifery Directives of the EEC. This was a particularly difficult situation as the CMB was in favour of only one route to becoming a midwife: aspiring midwives should be nurses first. The draft Midwifery Directives of the EEC, and the CMB (E&W) recognised two ways: (1) midwifery courses for women who were nurses first; and (2) direct entry courses. The CMB found it difficult to accept this view. The

EEC Directives also forced the CMB to extend the length of the one-year midwifery course.

The re-organisation of education also emerged from the Briggs Committee on Nursing which was appointed in 1970 and reported in 1972. Margaret Auld, the only practising midwife on the Briggs Committee described its purpose as follows:

it was given the remit to look at the manpower needs of the country, the way in which nurse/midwifery training was carried out... the way in which nurses and midwives were prepared... and to decide the appropriate way that this training [and preparation] should be organised and monitored.<sup>1</sup>

I shall examine how the Board handled the Briggs Committee's recommendations which not only advocated changes in education of nurses and midwives but also changes in their statutory framework which eventually brought about the CMB's end in 1983.

To enable the CMB to cope with what became an increasingly heavy workload it appointed an Executive Committee in 1960 and a salaried Education Officer who worked closely with the Board. I shall begin by discussing these administrative innovations.

### **The Executive Committee of the CMB: its formation and function**

By 1960 the CMB had been in existence for forty-four years. Its main committees were those dealing with finance, penal cases and issues surrounding examinations, with other temporary committees established on an *ad hoc* basis. I have already commented on how slowly the Board appeared to work. Its actions suggest the Board felt the same, as in February 1960 it began to consider forming an Executive Committee to facilitate its administrative functions.<sup>2</sup> As this Committee quickly became essential to the Board's

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<sup>1</sup> Oral testimony. For details of the oral interviews conducted in relation to this research, see Appendix 4. LR 25 [105].

<sup>2</sup> NAS, CMB 1/8, CMB Minutes, 11 February, 1960, p 2.

work and remained thus until the Board's demise in 1983, it is appropriate to record its inception. The purpose of the Executive Committee was to make the work of the Board more expeditious and efficient. It consisted of eight members (half the Board membership), including *ex officio* the Chairman and Deputy. The Committee, meeting every four weeks, had the power to deal with day to day matters of the Board without waiting for the next full Board meeting.<sup>3</sup> Thus, the overall work of the Board ran more effectively and with greater awareness of emerging relevant matters of policy, as it was part of the Committee's remit to bring them before the Board. Its initial tasks were: to deal with redrafting the Rules and statutory forms especially in the light of modern midwifery practice; and, to organise the appointment of an education officer to the Board.<sup>4</sup>

### **First Education Officer to the CMB**

The creation of the salaried post of education officer to the Board in early 1961 was an important administrative innovation as it demonstrated the serious nature of the Board's attitude to the education of midwives by having one person with clear duties in this field. The education officer to the Board would be a qualified RGN, SCM and MTD with an extensive job-description. She was expected to go all over Scotland in pursuance of her duties which included inspection of: recognised midwifery training institutions and those seeking recognition; approved teachers of midwifery on district and those applying for approval. She had to be available for advice on training when requested by hospital, teachers or a LA; and attend different CMB examination centres from time to time; and,

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<sup>3</sup> The Board originally planned to meet monthly. In 1947 this Rule was officially reduced to quarterly unless otherwise decided at a previous meeting.



in conjunction with the Board Secretary, compile a rota of examiners for each CMB examination. She also was required to report on her work to the CMB and undertake any other relevant duties arising. By December 1960 the post was approved, advertised, and awarded after interview to Miss J H Beckett at a salary of £1000 per annum rising to £1200 with annual increments of £40 and a start-date of 3 April 1961.<sup>5</sup> Miss Beckett was an eminently suitable person for the post of first Education Officer to the Board. She was already a Board member and thus well aware of the way the Board operated. Also, she was elected to the Board by certified midwives practising in Scotland. She was therefore well known and respected by midwives in Scotland and this helped them accept the concept of the new post.

When Miss Beckett retired in 1973, Miss Annie Grant, also a Board member, became Education Officer until her retiral in 1982. By this time the Board was aware that existing statutory nursing and midwifery bodies would be dissolved to make way for the new United Kingdom Central Council (UKCC) and National Boards (see below). The Board informed the SHHD of its concerns about the future of practice and education within midwifery. Thus, the National Board for Scotland (NBS) appointed a Professional Officer (Midwifery and Examinations) with effect from 14 September 1982: Miss Veronica E Pope, previously Senior Tutor at the Queen Mother's Hospital School of Midwifery. The NBS seconded Miss Pope to the CMB to act as its Professional Officer following Miss Grant's retiral until the Board relinquished its statutory duties.<sup>6</sup>

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<sup>4</sup> NAS, CMB 1/8, CMB Minutes, 14 April, 1960, p 1.

<sup>5</sup> NAS, CMB 1/8, CMB Minutes, 27 July, 1960, p 1; NAS, CMB 1/8, CMB Minutes, 7 December, 1960, p 1.

<sup>6</sup> The NBS was set up in September 1980; CMB Report, 31 March, 1983, p 4; NAS, CMB 1/9, CMB Minutes, 18 March, 1982, p 3; NAS, CMB 1/9, CMB Minutes, 17 June, 1982, p 1.

### **Loss of midwifery matrons, status and career prospects**

The advent of the NHS brought changes to the administration of maternity services which impinged on the place of birth, continuity of care for mothers, and midwives' practice.

Across the NHS in its early years there was a rising tide of expenditure which warranted investigation. In 1953 the Minister of Health and the SOS for Scotland appointed a committee under the chairmanship of C W Guillebaud (the Guillebaud Committee) to review NHS finances. When the Committee reported in 1956, it 'revealed the potentially unlimited demand for health care and the necessity of containing that demand within a finite budget'.<sup>7</sup> Specifically, the Guillebaud Committee, while acknowledging the imperfections of the tripartite structure of the NHS, highlighted the confused state of the maternity services and recommended their review.<sup>8</sup>

In response, in 1956, the Government set up the Cranbrook Committee in England and Wales, and the Montgomery Committee in Scotland, to review and report on the maternity services. The Montgomery Committee's remit was to consider what the NHS should provide for the mother and child during pregnancy, confinement and lying-in, and to advise on the best way of doing this within its framework.<sup>9</sup> The Committee invited written evidence from relevant organisations and bodies in Scotland, including the CMB.

The Board directed its response to three aspects: antenatal care, care during and after confinement, and administration. While the CMB mentioned the midwife as a role-player in maternity care, its comments on midwives were luke-warm and it missed an opportunity to highlight the role of the midwife. For example, in the section on antenatal

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<sup>7</sup> J Brotherston, 'The National Health Service in Scotland: 1948-1984', in G McLachlan, ed, Improving the Common Weal: Aspects of Scottish Health Services, (Edinburgh: Edinburgh University Press, 1987), p 148.

<sup>8</sup> Ibid, p 260; J Towler and J Bramall, Midwives in History and Society, (London: Croom Helm, 1986), p 251.

care, the CMB commented 'if the case is a normal one and the doctor [GP] undertakes to carry out antenatal care, the midwife should be given a reasonable share in antenatal supervision and treated as a colleague'.<sup>10</sup> The CMB's comments could have stressed the role of the midwife as a practitioner capable of undertaking the full care of a mother in a normal child-bearing episode.<sup>11</sup>

In the section on care during and after confinement the CMB emphasised the fact that home births remained a satisfactory option for many women but omitted to stress the importance of the midwife's role in home births where the midwife delivered most of the babies. (The word 'midwife' is mentioned once in this section.)<sup>12</sup> It may be that the CMB took this as understood. Nevertheless, it is ironic that in the last section, on administration, the Board revealed its concerns for the recruitment, retention, autonomy and career prospects of midwives in Scotland when elsewhere it failed to stress the importance of midwives and their role.

The provision of an adequate number of well-educated, well-trained and experienced midwives is essential to an efficient Maternity Service but today there is a grave shortage of practising midwives... One of the factors contributing to this shortage is the tendency to merge Maternity Hospitals with general Hospitals without ensuring the autonomy of midwifery administration... all *ad hoc* maternity hospitals of fifty beds or more should be under the control of midwifery matrons and that... Boards... should make it possible to separate their midwifery administration from the general hospital.<sup>13</sup>

This administrative problem was to increase in the years to come. Until 1960, with a few exceptions, a midwife in charge of a maternity unit in Scotland, whether stand-alone or part of a larger hospital, carried the nomenclature and status of Matron.

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<sup>9</sup> NAS, CMB, 1/7, CMB Minutes, 18 October, 1956, p 2.

<sup>10</sup> NAS, CMB, 1/7, CMB Minutes, 14 February, 1957, Statement by the CMB to the Scottish Maternity Services Review Committee, pp 1-3.

<sup>11</sup> DHS, Scottish Health Services Council, Maternity Services in Scotland, the Montgomery Report, (Edinburgh: HMSO, 1959), Chapter 5, paras 57-102.

This term, although belonging to the nursing hierarchy, gave the top midwifery post in a maternity unit equal standing with senior nursing colleagues. As the Board revealed in its comments to the Montgomery Committee, administrative change was eliminating the role of the midwifery matron. The CMB's concern emerged during Board meetings in the early 1960s when it found that it was powerless to prevent this loss of administrative autonomy within maternity units.

An early example of this loss of autonomy appeared at the Vale of Leven Hospital (VOL). In 1960 the West Regional Hospital Board (WRHB) which administered VOL, proposed that instead of having a midwifery matron, its maternity unit would be under the Matron of VOL. Thus the superintendent midwife would have a lower rank administratively than the matron of VOL. The Board expressed its grave concern to WRHB and stated unequivocally that maternity units should be administered by a midwifery matron.<sup>14</sup> Change, as proposed by WRHB, would reduce not only their power and status but also the quality of the training of midwives in hospitals.

The recruitment, supervision of training and general nursing administration of a midwife teaching school required the attention of a Matron rather than that of a Superintendent Midwife. In some instances the matron of the general hospital concerned made herself responsible for the recruitment and training of midwives, at the same time having to give her major attention to the enrolment and training of student nurses in the general departments of her hospital.<sup>15</sup>

Also, as many women who trained as midwives did not remain in midwifery, this change imposed limitations on the possibility of promotion to the highest level within midwifery

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<sup>12</sup> NAS, CMB 1/7, CMB Minutes, 14 February, 1957, Statement, pp 1-3.

<sup>13</sup> Ibid.

<sup>14</sup> NAS, CMB 1/8, CMB Minutes, 7 December, 1960, p 2.

<sup>15</sup> NAS, CMB 1/8, CMB Minutes, 21 September, 1961, p 5.

with implications for the attractiveness of a career in midwifery and a consequent effect on recruitment and retention of midwives.<sup>16</sup>

The Executive Committee of the CMB, disappointed that the WRHB was not to be moved on this issue, wanted to retaliate by refusing approval of VOL as a training school for pupil midwives.<sup>17</sup> However, on the advice of Mr Reid, (SOS's observer) the Board did not approve this motion and further meetings between the Executive Committee, the DHS and the RCM Scottish Council reached no conclusion.<sup>18</sup>

It is probable that the representatives from the DHS saw that administrative change was inevitable. The Board, too, had to come to terms with this. Recognising that the post of midwifery superintendent instead of midwifery matron in a maternity unit within a larger hospital was inescapable, the Board turned its concern to the procedure for making appointments to senior posts. It urged the SHHD to recognise the importance of having a midwife on the interviewing panel for senior nursing posts involving midwifery.<sup>19</sup> Although Regional Boards decreed that only one assessor should be from the nursing profession (which in their eyes included midwives), the SHHD acknowledged the CMB's concern. In 1964 Dundee Royal Infirmary (DRI) appointed a Matron who was not a State Certified Midwife. At the SHHD's invitation, the Board's representative, Miss Beckett, went to Dundee and ascertained that the Midwifery Superintendent was being given the control over her department which the CMB had stipulated. Nevertheless, the CMB reiterated to the SHHD that it was unsatisfactory to appoint a matron who was not a practising midwife with no practising midwife on the assessment panel. A non-

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<sup>16</sup> R Mander, 'Who Needs Midwifery?', in *Nursing Times*, Vol. 83, No. 26, 1 July, 1987, pp 34-35.

<sup>17</sup> NAS, CMB 1/8, *CMB Minutes*, 16 March, 1961, p 3.

<sup>18</sup> NAS, CMB 1/8, *CMB Minutes*, 11 May, 1961, p 3.

<sup>19</sup> Previously the DHS.

midwife assessor would not ask a candidate appropriate questions about midwifery within the hospital, and might not stipulate what was expected regarding midwifery. Further appointments with midwife assessors demonstrated that some regard was being paid to the Board's recommendations, although from the Board's point of view, the situation could never satisfactorily be resolved.<sup>20</sup>

Similar problems arose in midwifery education where the Board found that recruitment and training of student midwives might come under a principal who was not a midwife.<sup>21</sup> This came to light first at the new Foresterhill College of Nursing, Aberdeen which the CMB agreed could undertake the theoretical training of student midwives by lecturers and teachers approved by the Board. When the post of Principal to the College was advertised in 1966, the Board realised that the Principal would be directly in charge of recruitment and training of student midwives.<sup>22</sup> According to the Rules of the Board, teaching institutions could only be approved if they conformed to certain prescribed requirements and under their terms this did not apply to this College. Miss Young, the CMB's Secretary, reminded appropriate senior staff in Aberdeen that although the CMB had agreed to the theoretical element of teaching student midwives being carried out at the Nursing College, that was where the responsibility of the College ended. Thus, Aberdeen Maternity Hospital remained the approved training institution, with the matron in charge of the recruitment and training of student midwives who received theoretical training in the college.<sup>23</sup> The Board's influence was further enhanced by the North-

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<sup>20</sup> NAS, CMB 1/8, CMB Minutes, 20 February, 1964, p 2; NAS, CMB 1/8, CMB Minutes, 17 September, 1964, p 2; NAS, CMB 1/8, CMB Minutes, 17 December, 1964, p 1.

<sup>21</sup> The term 'student midwife' gradually superseded 'pupil midwife' in the 1960s. It was made official in the CMB Rules, 31 March 1968, p 5; CMB Report, 31 March, 1968, p 2.

<sup>22</sup> CMB Report, 31 March, 1967, p 3.

<sup>23</sup> After the RCM Scottish Council drew the CMB's attention to this case, the Board appears to have acted very speedily; NAS, CMB 1/8, CMB Minutes, 21 July, 1966, p 2.

Eastern Hospital Board's invitation for the CMB to nominate one of three assessors to appoint a Principal to the College.

### **The Salmon Report**

Although the Foresterhill College case had a good outcome from the Board's point of view, administrative change in both management and education of nurses and midwives was inevitable. This became even more apparent when the Minister of Health and the SOS for Scotland appointed a Committee under the Chairmanship of Mr Brian Salmon which reported in 1966. This came in the middle of what Davies and Beach describe as 'a decade of disquiet within nursing' with concerns over structure of the nursing service, its status within the NHS, and the standard and method of nurse training.<sup>24</sup> Inevitably, given the strong links between the two professions, midwifery was included within the Salmon Committee's remit: to review and advise on the senior nursing (including midwifery) staff structure in the hospital service (ward sister and above), the administrative function of the respective grades and the methods of preparing staff to occupy them.

The Salmon Committee invited the Board along with other relevant groups, to give written and oral evidence in early 1964. This time the Board strongly promoted the case for the importance of midwives especially for the retention of midwife matrons.<sup>25</sup> Support came from the Scottish Standing Committee of the RCOG who wrote to the Chief Medical Officer, the SHHD, expressing its unanimous opinion that obstetric units

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<sup>24</sup> C Davies and A Beach, Interpreting Professional Self-Regulation: A History of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting, (London and New York: Routledge, 2000), p 3.

<sup>25</sup> NAS, CMB 1/8, CMB Minutes, 16 December 1965, p 5.

of fifty beds and over should have an independent Maternity Matron with administrative autonomy.<sup>26</sup>

The Salmon Committee's Report, published in 1966 and implemented in many areas in Scotland in the 1970s, 'completely changed the management and administration of nursing [including midwifery] in hospitals'.<sup>27</sup> It eliminated midwifery matrons with administrative autonomy. Job descriptions for nurses and midwives were graded from the top Grade 10 to Grade 6, ward sister. Margaret Clark, Nursing Officer, SHHD, while acknowledging the need for the Salmon Committee's work and Report, said that it was implemented before full evaluation of its pilot studies. The ensuing hierarchy was divisive and what became known as 'the Salmon structure', when implemented across the country, thoughtlessly standardised 'an amorphous organisation'.<sup>28</sup>

Midwives in management and education had varying opinions about the Salmon structure. Joan Savage, Matron of the Elsie Inglis Memorial Maternity Hospital, Edinburgh, recalled problems she encountered.

I enjoyed my time there until re-organisation came. Salmon came first... with all their numbers. I was a number eight. They made my tutor a number seven and I said she should be a number eight as well... it made a difference to her salary [and] she was as important... we had a number nine over us... she was floating... and we used to get directives from this number nine. And one included how to get the patients to write a will. I thought this is nonsense. You know this is a maternity hospital not an old age – that [Salmon structuring] made a lot of difference and the change – you see the Matron used to be in charge of everything – kitchen, domestic staff. They knew who to go to. You knew who needed help – then the kitchens... and domestics... went into some other [management] outwith the hospital.<sup>29</sup>

<sup>26</sup> NAS, CMB 1/8, CMB Minutes, 15 July 1965, p 1.

<sup>27</sup> J Main, 'Nursing: Nursing, Midwifery and Health Visiting', in G McLachlan, ed, Improving the Common Weal: Aspects of Scottish Health Services 1900-1984, (Edinburgh: Edinburgh University Press, 1987) p 477.

<sup>28</sup> M Clark, 'Changing Clinical Practice in Nursing', in A Duncan and G McLachlan, eds, Hospital Medicine and Nursing in the 1980s: Interaction between the Professions of Medicine and Nursing, pp 50-51.

<sup>29</sup> LR, 34 [109].



Joan Spence working as a midwife in Aberdeen Maternity Hospital felt that the coming of the Salmon structure precipitated promotion upon some who were not ready.

It was Salmon in 1974 – Salmon came in and all these very experienced ward sisters were shunted out to walk the corridors as Nursing Officers and there was a group of us and we were told we were going to be sisters. We weren't in an interview situation where you were applying. We were told. I was told I was going to be a relief sister between the nursery and the postnatal wards. I remember saying to the assistant-matron, 'I don't really want a sister's post.' I was more or less told that you either did it or you would never get another one. So we were all promoted.<sup>30</sup>

Margaret Auld went to the Borders in 1973 as Chief Area Nursing Officer. She acknowledged the danger of over-structuring the service. However, as part of the Salmon Committee's recommendations included improvements in practice, education and career structures, the need to re-structure services in the Borders was apparent although she encountered some problems.

They had not had Salmon imposed down here then, so I re-organised it when I came, with the [Health] Board's approval of course. Everything had to go to them ... in retrospect we did it too much. There was not the need for the number of nursing officers we put in here. Well ... we learn by trial and error. It was just too structured... There were a number of small hospitals – in Duns, Coldstream. Kelso, Jedburgh, Hawick, Galashiels and Peebles, each with some midwifery beds. Some I remember as little as two and some as many as twenty plus. The equipment was awful. It was ... very bad ... and so we decided to centralise a bit and that caused a great deal of angst.<sup>31</sup>

Obtaining midwives and maintaining their skills in an area with a low birth-rate was also difficult. Margaret Auld commented:

It might have been better if we had kept some of the beds but ... you could not get the midwives. The cover was very difficult to maintain for these beds... Because, there wasn't the work... the birth-rate here is... very low... The population at that time – it's grown now but at that time it was ninety-five thousand ... for the whole area... and it's a very very elderly population, the Borders... [The birth rate has] gone up a bit now because we've got more younger people coming in but it was very low. So you might have a midwifery unit and one delivery a week... and

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<sup>30</sup> LR, 32 [95].

<sup>31</sup> LR, 25 [105].

you'd have a midwife sitting there and, doing nothing and you were having to pay [her]. A very expensive service. And not keeping her skills up at all. So it [was] better to centralise a bit so that you could properly staff these places, make sure that everybody was up to date and we started sending ... [midwives] up to the Simpson to get updated.<sup>32</sup>

There were also problems and anomalies for those teaching in midwifery. The Salmon Committee's proposals did not include an equivalent of a principal Nurse Tutor Grade 9 for midwives. The most a senior midwife tutor could hope for was Grade 8. The CMB argued that this would adversely affect the status of midwife tutors with a subsequent effect on midwifery teaching and practice as current and future midwife teachers might turn to general nurse teaching or into management to facilitate career advancement.<sup>33</sup> Yet Margaret Kitson, an exception to the trend, explained what happened to her in Glasgow.

In 1970 I came to Rottenrow as the principal tutor there. Miss Burrows retired and I went there and I stayed there until September '76... During that time the Salmon Structure was introduced and I was the only Principal Nursing Officer (Midwifery Teaching) in Scotland and that was ... purely an accident of the Salmon grading. It was exactly the same as a principal tutor's job. But because there was a chief nursing officer (midwifery), a grade 10 post for the management of midwifery, there was a grade 9 post for the teacher so, if you like, there was no difference in the job but there was a difference in the grading.<sup>34</sup>

The experience of others, such as Peggy Grieve, confirmed the CMB's fears. Working in midwifery teaching at Cresswell Maternity Hospital in Dumfries, Peggy Grieve found that the Salmon structure gave her a lower grading than she would otherwise have had. Because of this she decided to move from midwifery teaching to management.

They employed another tutor and [therefore] I was the senior tutor. Then of course the Salmon structure came in and my grade was [reduced] because it was not a big enough hospital... for the senior person [in midwifery teaching] to be a principal nursing officer. I was only at the grade of nursing officer. Well I [appealed to] the College [the RCM] at that time and the Scottish Home and

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<sup>32</sup> *Ibid.*

<sup>33</sup> *CMB Report*, 31 March, 1969, p 4.

<sup>34</sup> *LR*, 41 [120].

Health Department, you name it and I got nowhere. So I thought well, right, I'm not going to do this.<sup>35</sup>

Gelda Pryde who worked for many years in Angus agreed that the Salmon structure did not favour midwife teachers. However she felt that restructuring of management was, in the main, a good and necessary move.

And it could be that the Salmon structure really wasn't so favourable to midwifery tutors that so many of them turned to management. I suppose there were more management posts and they...were different. It wasn't a matron sitting in an office. They really had a much higher pinnacle content to some of the management folk. They became nursing officers or senior nursing officers for groups of wards so they really were involved again with almost direct care if they were needed. I think it [Salmon restructuring] was a good thing...it certainly brought management and clinical practice closer together. When I came to Angus...there were matrons in every small hospital. So I had something like ...eight matrons. That would be in 1973 ... The Angus post [as senior nursing officer] attracted me rather than all the other senior management posts because the ones in the big hospitals were purely for general [nursing] but this one had the three maternity units and of course midwifery having been my main love, that was why I came here. But...[the] eight matrons... had all applied for this senior nursing officer post on two occasions and this was the third time it was interviewed when I saw it and applied and of course I got it – I had a very dodgy time – I was not Miss Popular when I first came. They then became nursing officers of their various units, both in midwifery and in general and because my post took away a lot of the pure management from what they had previously done, they then had the time and the remit [included] in their job to be more clinically involved...I do think this was a good thing...Because I was there...with an overview of all the units, I could then begin to update the ones that really had fallen behind because they were all very isolated. They didn't really ever seem to meet together. [The people in the Fyfe Jamieson] didn't talk to the person in the maternity unit in Arbroath and they didn't really have much contact, other than perhaps social contact with Montrose. But because my meetings brought them all together then they obviously began to discuss their ways of working in each unit. I think it made quite an impact on [them] when I did that...[They were] number seven [and I was a number] eight. I think I was perhaps more readily accepted by the midwifery nursing officers because they obviously realised that I had a lot of midwifery expertise and they were reasonably happy [although some missed the title 'matron']... And I think the doctors resented [the changes] very much. We had a lot of battles with them... [because], I think more power to the midwives probably...I think they saw me as a threat because again there was quite a lot of

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<sup>35</sup> LR, 16 [102].

GP midwifery practice and some of it, well, didn't really come up to the standard that I would have liked.<sup>36</sup>

Thus the recommendations of the Salmon Report which included recognition of the need to look more closely at practice, to be more aware of the importance of research and continuing education, and to facilitate a clinical career structure for nurses<sup>37</sup> were only partly fulfilled as far as midwifery was concerned. In the main, the report's implementation hindered a career structure for midwife teachers. The CMB emphasised these issues in their recommendations to the Briggs Committee in 1970, as will be discussed below.

### **Integration of midwifery services**

With the enactment in 1974 of the 1972 National Health Service (Scotland) Act, the tripartite administration of the NHS in Scotland ended. It was clumsy, disjointed and inefficient, and did little, if anything, to achieve co-operation between professionals working within the NHS. In 1967 William Ross, SOS, announced a 'thorough examination of the administrative structure of the health services in Scotland'. The result was a Green Paper published in 1968, proposing to slim down the huge administrative network of the original NHS from five regional boards, twenty-five executive councils, fifty-six local health committees and sixty-five boards of management to what eventually became fifteen Health Boards.<sup>38</sup> Re-organisation centred round two aims. The first was to improve patient care, by integrating personal health services 'round the patient' and developing a preventative community-based system of health care. The second aim was

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<sup>36</sup> LR, 42 [69].

<sup>37</sup> Clark, 'Changing Clinical Practice in Nursing', pp 50-51.

<sup>38</sup> D Hunter, 'The Re-organised Health Service', in M G Clarke and H M Drucker, eds, Our Changing

to provide these services within a unified yet supportive and flexible management system whose long-term planning process would have a building-block effect as the future NHS in Scotland developed.<sup>39</sup>

Integration of the maternity services in Scotland after 1974 was part of the wider plan for change in health service administration in Scotland. The Montgomery Committee reporting in 1959 recommended greater co-ordination of the disparate arms of the maternity services under one person: the GP. This would reduce confusion and increase continuity of care for mothers. Yet, by the mid-1960s the service remained disjointed. For instance, if a woman was having a hospital birth, hospital staff usually accepted antenatal responsibility for her. Thus, the GP handed over care of a woman who attended him originally. The domiciliary/district midwife employed by the LA often did not see the mother before the birth. She had nothing to do with the birth and saw the mother and baby postnatally on their discharge. This became increasingly early, to accommodate the demand for maternity beds. So, the domiciliary midwife did little antenatal and intranatal care and thus did not practise holistically, leading to loss of both skills and job satisfaction. From the mother's point of view, she did not receive continuity of care as she saw different doctors and midwives at the clinics, had an unknown midwife to deliver her and did not become acquainted with her district midwife until post-delivery.

One proposed answer to the problem, which gained favour in the 1960s was integration.<sup>40</sup> Even before Government reports in the 1970s, this was happening on a

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Scotland: A Yearbook of Scottish Government, 1976-77, (Edinburgh: EUSPB, 1976), pp 32.

<sup>39</sup> Ibid, p 32; Brotherstone, 'The National Health Service in Scotland: 1948-1984', pp 130-133.

<sup>40</sup> R Peters, 'Nursing and Midwifery Services' in R Peters and J Kinnaird, in Health Services Administration, (Edinburgh: E & S Livingstone Ltd, 1965), p 318.

pragmatic basis between the three branches of the maternity services.<sup>41</sup> Government attention turned to integration in 1971 when the SHHD appointed a Joint Sub-Committee of the Standing Nursing and Midwifery Advisory Committee and the Standing Medical Advisory Committee of the Scottish Health Services Council under the Chairmanship of Dr R A Tennent. Its remit was: 'to examine the integration of the maternity and midwifery work of the hospital and the specialist, general medical and local health authority services in Scotland and to make recommendations'. As the CMB considered total integration of the maternity services in Scotland to be essential it responded willingly to the Tennent Committee's request for comments and recommended that ultimate clinical responsibility for women in each childbearing episode should be in the hands of a consultant obstetrician. The place of birth for all would be hospital, the selection of which, consultant or GP unit, would be according to an agreed policy. Commenting on the role of the midwife, the CMB emphasised that midwives should be essential members of the team, ante, intra and postnatally. Nevertheless to be a team player did not mean parity of status. In the labour ward particularly, the CMB made it clear that the midwife should 'carry out measures of treatment as delegated by the medical staff'.<sup>42</sup>

Obstetricians were influential in the production of the 1970 Report of the Standing Maternity and Midwifery Advisory Committee under the chairmanship of J Peel (the Peel Report) which preceded the Tennent Report by three years.<sup>43</sup> For the first time a

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<sup>41</sup> SHHD, Maternity Services: Integration of Maternity Work, the Tennent Report, (Edinburgh: HMSO, 1973).

<sup>42</sup> NAS, CMB 1/9, CMB Minutes 16 December, 1971, Appendix IV, 'Comments on the Integration of Maternity Services', pp 1-2.

<sup>43</sup> R Campbell and A Macfarlane, 'Recent Debate on the Place of Birth', in J Garcia, R Kilpatrick and M Richards, The Politics of Maternity Care, (Oxford: Clarendon Press, 1990), p 217.

Government Report advocated 100% hospital delivery on the grounds of safety, although there was no supporting evidence for this.<sup>44</sup> Although the Peel Report did not apply to Scotland, the Tennent Report, while acknowledging the geographical and demographical differences to be taken into account in Scotland, agreed with its main conclusions and recommendations.<sup>45</sup> The term '100% hospital confinement' is implicit in the Tennent Report's text, and its recommendations regarding place of birth are some of sixty-one recommendations on further integration of the maternity services in Scotland. For the midwife, the recommendations highlighted her role as a member of the team, and acknowledged the problems of keeping clinically up to date and maintaining a satisfactory career structure. The Report advocated greater co-ordination between community and hospital which would improve midwifery care for mothers and enhance the professional development of midwives within a district.<sup>46</sup>

The Tennent Report and its recommendations for an integrated maternity service fitted in with the introduction of the re-organised health service in Scotland in April 1974. The formation of single Health Boards instead of the previous tripartite system provided the opportunity for greater cohesion between hospital and community.

### **The European Economic Community: The Midwifery Directives**

In 1972 the UK became a member of the European Economic Community (EEC), joining France, Italy, Germany, the Netherlands, Luxembourg and Belgium. This was a long-talked-about step resulting in changes within every part of society, including the profession of midwifery. As well as coping with changes brought about by the demise of

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<sup>44</sup> *Ibid*, p 218.

<sup>45</sup> Tennent Report, p 2.

midwifery matrons, the Salmon Report, integration of maternity services in Scotland, and the Briggs Report which will be discussed below, the Board had to handle issues brought about by the UK's entry into the EEC and subsequent new cross-EEC rules for the education of midwives. These new problems centred on old issues: firstly the solipsistic attitude of others who ignored the Board or did not realise that the Board existed; secondly, who might enter training in midwifery and how long were courses to be. For a long time the CMBs of Scotland, and England and Wales had held varying opinions, one of the most recent of which was the cessation of direct-entry midwifery training in Scotland in 1968.<sup>47</sup> In the 1970s it was necessary, because the UK became a member of the EEC, to try and resolve their differences and speak with one voice while negotiating the EEC Midwifery Directives.

CMB Minutes first mention the EEC in December 1970. Mr Mitchell of the SHHD informed the Board that existing members of the EEC were currently discussing midwifery training. He asked the Board to consider the position of mutual recognition of midwifery qualifications in the light of the UK's possible entry into the EEC.<sup>48</sup> It was important that the CMB should have a voice on any UK-wide discussion on midwifery, firstly because it was an independent Board, equal in status to the CMB (E&W), and secondly because midwifery in Scotland varied considerably from England and Wales, particularly when it came to training. The Board was concerned that it had not been included in on-going discussions on the EEC; until September 1971 all business had been conducted by the Secretary of the CMB (E&W) and 'England was apparently recognised

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<sup>46</sup> *Ibid*, p 13; *Ibid*, Chapter 8, 'The Role of the Midwife in an Integrated Maternity Service', pp 29-31.

<sup>47</sup> *CMB Rules*, 1968, p 5; *CMB Report*, 31 March, 1968, p 2. This development slipped through with little comment.

<sup>48</sup> NAS, CMB 1/8, *CMB Minutes*, 17 December, 1970, p 3.



as synonymous with Britain'. A joint meeting proved difficult to arrange and the DHSS compiled the publication, The Common Market and the Nursing Profession, in consultation with the CMB (E&W) but not with the CMB for Scotland.<sup>49</sup> The Board could not accept that the CMB (E&W) was in any position to speak for midwifery in the UK as a whole.

The first draft EEC Midwifery Directives were published in 1972. They stated that a person could become a midwife in two ways: firstly after three years midwifery training (direct entry) and secondly after two years midwifery training following general nurse training.<sup>50</sup> This required in-depth consultation which was not happening inside the UK. Officials from the six member countries and other acceding countries set up a Midwifery Liaison Committee (MLC) to discuss the draft Directives in Brussels. UK Health Department officials could attend this meeting but not representatives of the UK Boards as the MLC comprised professional rather than statutory bodies.<sup>51</sup> It was necessary for the UK countries to set up a liaison committee to establish a common and constructive UK approach on the Directives. A first meeting planned for Edinburgh was postponed because the CMB (E&W) wanted to wait until the publication of the Report of the Committee on Nursing (the Briggs Report) which took place in October 1972.<sup>52</sup> When the meeting was held in London on 7 December 1972, there were representatives present from the CMB (E&W), the CMB, the NICNM, with guests from an Bord Altrains of the Republic of Ireland, as observers and Mr Mayoh of the DHSS. He

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<sup>49</sup> NAS, CMB 1/9, CMB Minutes, 16 September, 1971, p 2; NAS, CMB 1/9, CMB Minutes, 16 December, 1971, p 2.

<sup>50</sup> The Draft Directives conceded that an eighteen month training could be substituted provided a longer period of nursing had been achieved.

<sup>51</sup> NAS, CMB 1/9, CMB Minutes, 17 February, 1972, p 1; NAS, CMB 1/9, CMB Minutes, 20 April, 1972, p 1; Miss Annie Grant was invited to be representative for the RCM Scottish Council on this Committee.

<sup>52</sup> NAS, CMB 1/9, CMB Minutes, 21 September, 1972, p 1; NAS, CMB 1/9, CMB Minutes, 21 December.

explained that the MLC consisted of only professional bodies because there were no statutory bodies in the current six countries in the EEC. The issue of presenting a united voice became even more important because UK statutory bodies could not negotiate directly in these matters but would act through their respective Government departments.<sup>53</sup> Thus the UK Liaison Committee was set up comprising representatives of the UK Boards with observers from an Bord Altranais.<sup>54</sup>

Finding common ground within the liaison committee proved to be difficult.<sup>55</sup> At its first meeting, which Dr Matthew, Chairman of the CMB described as 'not helpful', the members could not agree on a common approach, particularly in regard to non-nurses being trained as midwives.<sup>56</sup> At the CMB's instigation, the SHHD agreed to consult further with the DHSS.<sup>57</sup> This was important as the Executive Committee was anxious to ensure that negotiation did not proceed on the assumption that the views expressed by the CMB (E&W) were the agreed views of the UK Midwifery Boards.<sup>58</sup> Further trouble came in January 1975 when attendance at an EEC Sub-committee meeting (about which the Scottish Board heard by chance) at the House of Lords highlighted the level of animosity between the Boards. Miss Bramley and Miss Young, CMB Secretary, found the Sub-Committee under the impression that the CMB (E&W) was the statutory body responsible for midwifery in the UK, and that it had received up to date information from the DHSS about the Directives which had never reached the Scottish Board. Also, prior to the meeting, Miss Bramley and Miss Young were called to meet the Chairman and

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1972, Appendix 1.

<sup>53</sup> NAS, CMB 1/9, CMB Minutes, 15 March, 1973, p 2.

<sup>54</sup> NAS, CMB 1/9, CMB Minutes, 21 December, 1972, p 1.

<sup>55</sup> NAS, CMB 1/9, CMB Minutes, 19 April, 1973, p 1.

<sup>56</sup> CMB Report, 31 March, 1974, p 2; NAS, CMB 1/9, CMB Minutes, 19 July, 1973, p 1.

<sup>57</sup> NAS, CMB 1/9, CMB Minutes, 20 December, 1973, p 2.

<sup>58</sup> Ibid, Appendix 2, p 2.

Acting Secretary of the CMB (E&W) so that they could speak with one voice, 'namely the English voice'. However, Miss Bramley would not agree to this. After Miss Bramley's meeting report to the CMB, the Chairman informed Mr Robert, Parliamentary Under Secretary of State for Health and Education at the Scottish Office of the situation. Secondly, he informed the Chairman of the CMB (E&W) that it did not have authority to speak for the UK and complained about their lack of effort to reach agreement with other statutory bodies as previously agreed.<sup>59</sup>

A further confused and frustrating meeting of the UK Liaison Committee in March 1975 brought two facts to light. Once the Directives were accepted, all the countries would have to conform to the types of training therein. This seemed to come as a surprise even to the CMB (E&W). Secondly, of the nine countries involved, only three currently had a direct entry midwifery course and of these, only two were in the original six when the Directives were drafted. The CMB therefore found it difficult to understand how a direct entry course had become one of the two types of course allowed by the Directives.<sup>60</sup> Nevertheless, realising that agreement must be reached, the Boards gradually began to come together, although the next argument regarding the extension of the midwifery course for registered nurses to eighteen months rumbled on. The CMB argued that, given good planning, the course could be done in one year and that there was no justification for extending it.<sup>61</sup> Finally, realising that the one year midwifery course

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<sup>59</sup> NAS, CMB 1/9, CMB Minutes, 20 February 1975, p 2.

<sup>60</sup> NAS, CMB 1/9, CMB Minutes, 17 April, 1975, p 1; CMB Report, 31 March, 1975, pp 2-3.

<sup>61</sup> NAS, CMB 1/9, CMB Minutes, 17 July 1975, p 1; also, see CMB Report, 31 March, 1976, p 2. To extend the course to eighteen months would conform with part of the draft Directives.

would not be acceptable in the context of the EEC Midwifery Directives, the CMB acquiesced.<sup>62</sup>

In 1979, after eighteen months of inactivity, negotiations over the EEC Midwifery Directives resumed in earnest. The other EEC countries agreed to a two-year post-nursing midwifery training. The UK, now speaking with 'one voice', wanted an eighteen month training with an additional period of six months experience after enrolment for midwives planning to practise in other EEC countries. The negotiators agreed the eighteen month training but stipulated a year's additional experience as a condition of free movement within the EEC. Finally, the EEC Midwifery Directives were agreed and signed on 21 January 1980 and Member States were required to conform with their requirements within three years.<sup>63</sup>

The next issue was one over which the CMB and the CMB (E&W) had disagreed for many years. In Scotland, nurses who were RFN, RSCN, Registered Mental Nurses and Registered Mental Deficiency Nurses were, if they wanted to be midwives, treated as RGNs and allowed to do the shorter midwifery course.<sup>64</sup> Although the CMB (E&W) eventually conceded that RSCNs could do the shorter course, all others in England and Wales had to do a longer course. The Midwifery Directives of the EEC stated that those doing the eighteen month midwifery course should be qualified in general nursing.<sup>65</sup> The only other way of becoming a midwife was by completing a three year course. This would put registered nurses in Scotland who were not RGNs and who wished to become

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<sup>62</sup> NAS, CMB 1/9, CMB Minutes, 18 December, 1975, p 3; NAS, CMB 1/9, CMB Minutes, 16 December, 1976, p 2; CMB Report, 31 March, 1977, p 4; The course was finally introduced with effect from 31 August 1981.

<sup>63</sup> NAS, CMB 1/9, CMB Minutes, 13 December, 1979, p 1; CMB Report, 31 March, 1980 p 3.

<sup>64</sup> By this time the RFN course was no longer obtainable in Scotland.

<sup>65</sup> EEC Council Directives, (80/154/EEC), Official Journal of the European Communities, 11 February, 1980, No L 33/3.

midwives, at a disadvantage after the Directives came into operation and Health Department lawyers could see no way round the problem.<sup>66</sup> To add to the predicament, from 1968, there was no direct entry midwifery course in Scotland. Members of the CMB continued to work on this with the GNC and the SHHD. Nevertheless, by the time the EEC Midwives' Directives came into effect on 23 January 1983 a solution had not been found.

The DHSS invited the Board to act as a 'competent authority' on all matters concerning midwives moving between Scotland and other member-countries and for ensuring that midwifery training in Scotland was in line with EEC requirements. This applied until the NBS took over the responsibility.<sup>67</sup> It seems ironic that after the years of being ignored and unacknowledged during the EEC negotiations, it should receive this communication from the DHSS (not the SHHD) inviting it to act on all matters to do with midwifery, Scotland and the EEC.

### **The Briggs Committee and beyond**

During the 1960s, the 'decade of disquiet,' it became apparent that there was a need to 'replace fragmented health services by an integrated structure of health care, concerned with prevention as well as with cure.' This need was partly fulfilled by the recommendations of the Montgomery and Tennent Reports of 1959 and 1973 and integration of the health service brought about by the reorganisation of the NHS. There was also unrest and insecurity over education and practice within the nursing and midwifery professions, which the implementation of the Salmon Report (see above) did

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<sup>66</sup> NAS, CMB 1/9, CMB Minutes, 18 December, 1980, p 1.

<sup>67</sup> NAS, CMB 1/9, CMB Minutes, 24 September, 1981, p 2.

little to alleviate. Against this background the Committee on Nursing was commissioned by the DHSS, the SHHD and the Welsh Office. This Committee's terms of reference were

To review the role of the nurse and the midwife in the hospital and the community and the education and training required for that role, so that the best use is made of available manpower to meet present needs and the needs of an integrated health service.<sup>68</sup>

The Committee on Nursing chaired by Professor Asa Briggs, comprised twenty members. Of these, three were from Scotland: Ivor Batchelor, Professor of Psychiatry, University of Dundee, Margaret Scott Wright, Professor of Nursing at University of Edinburgh, and Margaret Auld, midwife, Matron of the SMMP and CMB member who commented:

I was asked to go on the Briggs Committee in 1970 and I was very pleased to do so... I thought this would be a very interesting committee... Its remit was huge... [It had] to look at the way in which nurse/midwifery training was carried out and health visiting and district nursing and to decide the appropriate way that this training should be organised and monitored.<sup>69</sup>

Although the Committee was concerned about the different professions within its remit, because of requirements to work within existing resource levels, the Committee had to focus on the needs of the service rather than those of the professions.<sup>70</sup>

[We had to examine] the manpower needs of the country and the way in which nurses and midwives were prepared... I think it grew out of the fact that there had been... endless committees before us who said that there were shortages of nurses and midwives.<sup>71</sup>

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<sup>68</sup> DHSS, SHHD, Welsh Office, Report of the Committee on Nursing, Briggs Report, Cmnd. 5115, (London: HMSO, 1972), p 1.

<sup>69</sup> LR, 25 [105].

<sup>70</sup> Davies and Beach, Interpreting Professional Self-Regulation, p 5.

<sup>71</sup> LR, 25 [105].

The Briggs Committee also focussed on the existing statutory arrangements and what they saw as failings ‘namely the inflexible system of training and registration that had developed under its auspices’.<sup>72</sup>

There was a feeling that the way in which nursing was structured was wrong in the way in which you kept repeating bits of courses... if you wanted to take an additional qualification you found yourself repeating a whole lot of work and this was felt to be misuse of time. There was thought to be far too many registering bodies all overlapping... health visitors, the district nurses, nursing, midwifery.<sup>73</sup>

The Committee was committed to working very hard and quickly to complete its Report within an agreed timescale. This put its members under great pressure.

The Chairman Asa Briggs... promised the Government they’d have it in two years and the Report was actually written and prepared and presented in the two years. I think we visited... over a hundred establishments... Over a hundred people came and gave evidence verbally to the committee... We also had... written evidence... we employed three researchers full time... putting out questionnaires to find out what was the feeling in the profession.<sup>74</sup>

Because of the heavy workload, the Briggs Committee also had five sub-committees most of which Margaret Auld attended. ‘I was on a lot of them because I was the only [practising] midwife in the whole committee.’<sup>75</sup> This highlights the issue of ‘balance’ which remained sensitive during the Committee’s lifetime. Nurses were concerned that the Committee did not represent sufficiently ‘junior nursing staff from the provinces’ and, ‘midwives were uncomfortable with the inclusion of only one practising midwife’.<sup>76</sup>

The Briggs Committee met first in June 1970 and soon after, requested evidence from appropriate bodies including the CMB.<sup>77</sup> The Board’s written evidence to the Briggs Committee covered the role of the midwife in all areas of practice and the

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<sup>72</sup> Davies and Beach, Interpreting Professional Self-Regulation, p 5.

<sup>73</sup> LR, 25 [105].

<sup>74</sup> Ibid.

<sup>75</sup> Ibid.

<sup>76</sup> Davies and Beach, Interpreting Professional Self-Regulation, p 5.

problems of recruitment to midwifery. Because recruitment to midwifery depended now on recruitment into nursing, the Board addressed this as well, along with the current one year single period midwifery training course which had been satisfactorily operating for two years. Students needed teachers and the Board, stressing the importance of both tutors and clinical instructors, outlined their duties and how their training should go forward. In a strong statement, the Board gave its opinion on a career structure for midwives particularly after the implementation of the Salmon Report.

It has become apparent that midwifery is taking a subservient place to general and psychiatric nursing ... The overwhelming emphasis is on administration...and inclined towards general nursing...[Thus], the midwife is strongly discouraged from following a clinical or teaching path in her chosen career... The Board cannot emphasise too strongly that the midwife is an important and valued member of the obstetric team. She has a statutory authority for the special responsibilities she exercises in diagnosis and treatment and acts to a considerable degree on her own initiative... The Salmon structure does not give credit for these special responsibilities and status of the midwife and ... the only solution would be to have a separate structure for midwives...for administration, clinical practice and teaching so that the midwife can remain in one of these branches ...without losing status, prospects or salary.<sup>78</sup>

However, this did not match what the Board said at the beginning of its evidence. This said that the 'midwifery service should be based on 100% hospitalisation ...with ultimately 100% consultant responsibility', and integration of midwifery services was essential 'bringing together the consultant, the GP and the midwife as a team with the consultant accepting ultimate clinical responsibility'. The Board saw amalgamation of hospital and domiciliary midwifery services as a key point, with domiciliary midwifery met by hospital staff. While integration was important and necessary in the light of the re-organisation of NHS administration, the Board's comment on 100% consultant

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<sup>77</sup> NAS, CMB 1/8, CMB Minutes, 16 July, 1970, p 2.

<sup>78</sup> NAS, CMB 1/8, CMB Minutes, 17 September, 1970, Evidence for the Committee on Nursing, (Briggs Committee), Appendix II, pp 1-5.



responsibility and ‘consultant accepting ultimate clinical responsibility’ potentially took autonomy from the midwife. Yet, later in the evidence, the Board emphasised the midwife’s ‘statutory authority’.

The Briggs Committee faced controversial issues from nurses, including district nurses, and health visitors as well as midwives. Nevertheless, specific arguments from midwifery bodies required particular attention. Firstly, there was the issue of professional identity. The Committee affirmed the ‘distinctiveness of midwifery’, the midwife’s role as educator of medical students as well as student midwives, her history of independent practice (although only a vestige of real independent midwifery practice was left by the 1970s), and the strength of the development of midwifery, separate from nursing.<sup>79</sup> Midwifery statutory and professional bodies used these special features as arguments for continuing separate statutory regulation. The Briggs Committee did not agree. This was partly to do with the Committee’s decision to bring education of nurses and midwives much closer together, arguing that this would develop the hitherto relatively poor communication between nurses and midwives. In addition, the Briggs Report recommended that ‘in future all midwives should be nurses’.<sup>80</sup> While the CMB already had this rule in place, and still argued for separate statutory regulation, the Briggs committee saw it as a added incentive to fuse the separate structures. Furthermore, the Briggs Committee argued that statutory amalgamation of nurses and midwives would help them to be seen as a stronger body when it came to negotiating nursing and

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<sup>79</sup> R Dingwall, A M Rafferty and C Webster, *An Introduction to the Social History of Nursing*, (London: Routledge, 1988), p 172.

<sup>80</sup> *Briggs Report*, para 626.

midwifery policy. The committee saw this as a particularly important point in the light of the EEC draft proposals.<sup>81</sup> Margaret Kitson, CMB member, commented,

the reason for the setting up of the UKCC was really quite simple...that because we were part of the United Kingdom and because the United Kingdom had to speak with a single voice in Europe we had to have a single statutory body. End of story. We had to have it.<sup>82</sup>

Nevertheless, it is worth noting that neither the Scottish Church nor Scottish Law were required to amalgamate with their English counterparts when the UK joined the EEC. They were protected by articles laid down in the 1707 Act of Union between the Scottish and English Parliaments and national differences were preserved.<sup>83</sup>

Another important midwifery issue was that distinct national differences between the CMBs compounded professional sensitivities.<sup>84</sup> According to Davies and Beach, the written evidence of both CMBs to the Briggs committee conflicted on some fundamental points to the extent that the Committee required oral evidence from each body.<sup>85</sup> Davies and Beach emphasised the national differences which emerged at this meeting. Although CMB representatives hoped to liaise further with the GNC for Scotland, they did not want changes which included amalgamation with other UK bodies. They argued that gains already made in integrating maternity services in Scotland because of its smaller population and fewer training schools, might be lost if this were to happen.<sup>86</sup>

The Briggs Report, published in November 1972, contained seventy-five recommendations. The first five recommended extensive changes for the new statutory framework for midwifery and nursing. In particular, 'There should be a single central

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<sup>81</sup> Davies and Beach, *Interpreting Professional Self-Regulation*, p 8; *Briggs Report*, para 307.

<sup>82</sup> LR, 41[120].

<sup>83</sup> D Daiches, *Scotland and the Union*, (London: John Murray, 1977) p 132.

<sup>84</sup> Davies and Beach, *Interpreting Professional Self-Regulation*, p 8.

<sup>85</sup> NAS, CMB 1/9, *CMB Minutes*, 18 February, 1971, p 1; *CMB Report*, 31 March, 1971, p 3.

body responsible for professional standards, education and discipline in nursing and midwifery in Great Britain – the Central Nursing and Midwifery Council’, and three distinct Nursing and Midwifery Education Boards for England, Scotland and Wales, responsible to the Council’.<sup>87</sup> The plan for a Central Council and the Education Boards effectively signalled the end of the existing statutory bodies.

For midwifery, apart from the predicted end of the current statutory bodies, including the CMB, one recommendation in the first section was of particular importance. ‘Midwifery interests should be represented by a statutory Standing Midwifery Committee of the Council... which would advise the Council and Boards on midwifery education and have direct control of midwifery practice.’<sup>88</sup> Margaret Auld, as the only practising midwife on the Briggs Committee was very involved with this. She explained what happened.

I fought very hard to get a midwifery committee because I felt that midwives were different in their preparation... their work and ... responsibilities... there needed to be a committee... composed mostly of midwives from the four countries... [to] decide the appropriateness of preparation and so on. The committee with some reluctance from some members agreed to this – some members thought this was a divisive solution and favoured unification. I had thought we had won the argument because we’d written papers about the role and function of midwives and talked about her work and that we’d agreed that a statutory committee would be set up. I think it was almost at the penultimate meeting in London. We went down to the meeting on the Friday and there was a paper tabled which suggested that there would be a unified structure and I understood this to mean no separate midwifery committee. The UKCC would be a unified body composed of midwives, health visitors, nurses, district nurses and so on. The work required on behalf of these professions would be through the Council. I felt that everyone looked at me for a response. I was so angry I said I could not make a decision now – the paper was tabled, that I’d have to take it away and think about it.

Everyone else managed to leave the hotel that night. I could not get on the night sleeper so had to stay. I flew up to Edinburgh on the Saturday morning and

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<sup>86</sup> Davies and Beach, *Interpreting Professional Self-Regulation*, p 9; The GNC for Scotland was also against a single statutory body, because of the differences between Scottish and English law.

<sup>87</sup> *The Briggs Report*, p 212, 1 and 2.

<sup>88</sup> *Ibid*, p 212, 3.

thought about it – and I thought well what are the implications of this? So I had an informal discussion with a lawyer and tackled it anew with him – the implications and differences of being a unified body or working through a statutory committee. It became clear in my mind what I needed to do. I got in touch with the secretariat in London and said that I just couldn't go along with this and if they persisted, I would consider writing a minority report which of course nobody wants because it polarises opinion so much. So, for whatever reason the Statutory Committee for midwives was back in again.<sup>89</sup>

The Standing Midwifery Committee, with a majority of midwives, 'should include expert midwife and other members in addition to those belonging to the main Council'. It would advise the Council and Boards on midwifery education and act as the national statutory body concerned with the control of practice in midwifery.<sup>90</sup> This was implemented in the Act (see Table 5.1).

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<sup>89</sup> LR, 25 [105].

<sup>90</sup> Briggs Report, pp 187 and 188, paras 627 and 629.

**Table 5.1 New Committee Structure of the UKCC and National Boards in 1983**

<p align="center"><b>United Kingdom Central Council for Nurses, Midwives and Health Visitors</b></p>
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**Statutory Committees**

<p>Finance Committee * (FC)</p>
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<p>Midwifery Committee* (MC)</p>
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**Non statutory committees**

Training	Clinical Nursing Studies	Mental Nursing	Occupational Health Nursing
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**National Boards**

National Board for Scotland	English National Board	Welsh National Board	National Board for Northern Ireland
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FC *	MC*	FC*	MC*	FC*	MC*	FC*	MC*
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Local Training Committee	Local Training Committee	Local Training Committee	Local Training Committee
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In addition there were Joint Committees of the UKCC and the National Boards including Health Visiting JC\*, and other Joint Committees to do with training, clinical nursing studies, mental nursing, occupational health nursing and district nursing.

\* indicates statutory committees of the UKCC and NBs.

Source: 1979 Nurses, Midwives and Health Visitors Act , Chapter 36, sections 7, 8 and 9.

The Briggs Committee recommended controversial changes for midwifery education. In 1972, when the Briggs Report was published, women who wanted to be midwives in Scotland were required to do a one year single-part training following three years registered nurse training. Enrolled Nurses had to do eighteen months midwifery training before enrolling. The Briggs Committee recommended two ways of becoming a midwife. The first was following Registration as a nurse (three years): a twelve month course leading to registration as a midwife and the award of a higher certificate. The second was following an eighteen month Certificate in Nursing Practice (which the Briggs Committee recommended all student nurses and midwives should complete): an eighteen month course leading to Registration as a midwife and the award of a higher certificate. Therefore the Briggs plan was that a student could become a midwife in four or three years, depending on the route chosen.<sup>91</sup> The Briggs Report's educational recommendations for midwifery, coming as they did in the same decade as discussions on the EEC Midwifery Directives, were not fulfilled completely. Yet they paved the way for further discussion after the 1979 Nurses, Midwives and Health Visitors Act.<sup>92</sup>

The publication of the Briggs Report was not the end of the controversy although it could be seen as the end of the beginning. It took six years from the publication of the Report to the introduction of the Nurses, Midwives and Health Visitors Bill to the House of Commons. During this six-year period many differences of opinion within the professions in the UK emerged. The CMB's main opposition to the Briggs Report lay firstly in the recommendation for a central UK body arguing that it was unconvinced that this change would be for the better especially as midwifery in Scotland

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<sup>91</sup> *Ibid*, p 213, paras 16, 18-21.

<sup>92</sup> M Uprichard, 'The Evolution of Midwifery Education', in *Midwives' Chronicle*, January 1987, p 6.

would then be in a minority position.<sup>93</sup> Secondly, the CMB suggested that the Briggs Committee had reached this recommendation without sufficient evidence and thus could not justify such a change in the statutory framework.<sup>94</sup> Also, the Board opposed the recommended two routes to becoming a midwife and argued that this would lead to two grades of midwife (although this was not what the Briggs Committee intended), which would be divisive, and reduce career prospects for the three-year midwives. The Board's opinions were supported by Scottish midwives responding to a referendum on the issue in 1973 but with no effect.<sup>95</sup>

The Board was disappointed, if not surprised when the Government accepted the main recommendations of the Report in May 1974.<sup>96</sup> Nevertheless, the effort to modify the recommendations went on. Now that a Central Council was to become a reality, the next step was to press for maximum decentralisation of the proposed National Boards. In this the CMB worked with the GNC for Scotland who was now anxious to present a united Scottish front to enlarge the functions of the National Boards with a corresponding increase in autonomy.<sup>97</sup> Their representatives argued at meetings of statutory bodies and departmental officials that the National Boards should include education, finance, discipline and practice. This much wider set of responsibilities than originally envisaged would give the Boards maximum autonomy. Although English statutory bodies were opposed to this, the CMB drew hope from a Government statement

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<sup>93</sup> NAS, CMB 1/9, CMB Minutes, 21 December, 1972, Appendix 1, p 2; CMB Report, 31 March, 1973, p 2; NAS, CMB 1/9, CMB Minutes, 21 December, 1972, (Report of Meeting of Executive Committee with representatives of the RCM Scottish Board and the Scottish Midwives Teachers' Club), p 1.

<sup>94</sup> CMB Report, 31 March, 1973, p 2.

<sup>95</sup> Uprichard, 'The Evolution of Midwifery Education', p 6; NAS, CMB 1/9, CMB Minutes, 15 February, 1973, p 1-2; CMB Report, 31 March, 1973, p 3; CMB Report, 31 March, 1974, p 2; NAS, CMB 1/9, CMB Minutes, 15 February, 1973 pp 1-2.

<sup>96</sup> CMB Report, 31 March 1975, p 2.

<sup>97</sup> NAS, CMB 1/9, CMB Minutes, 1974, 19 September, 1974, p 2.

which recommended maximum de-centralisation to the Boards for issues other than those which required UK-wide uniformity.<sup>98</sup>

It became evident that it was not widely known what midwives and the CMBs did. Dr Matthew (representing the CMB) noted Department officials' surprise on learning of the responsibilities of the CMBs and that a Standing Midwifery Committee might not be enough to cope with the midwives' situation in the statutory structure.<sup>99</sup> The CMB argued that along with a Standing Midwifery Committee at Central Council level there should be one at National Board level to address the particular features of midwifery in each country of the UK, and at the same time increase the potential power of the national boards.<sup>100</sup> This eventually came to fruition as shown in Table 5.1.

A significant number of meetings degenerated into wrangles between English and Scottish representatives because of the degree of de-centralisation and delegation of function to the Boards at national level.<sup>101</sup> Margaret Kitson, midwife and CMB member, looked at reasons why these arguments happened.

There was still this very strong Scottish feeling... that, right or wrong, north of the border we were better in terms of, education and health service. I mean the services to the patient, that we were better than they were in England and we really didn't want to get tagged on to that lot down there. That was one thing... The other very trenchant thing was that we didn't want to be taken over. And we felt that with the formation of a UKCC, Scotland would just get lost and its identity would get lost...

Going to meetings in England was a very salutary experience... and not necessarily a happy one because no matter which meeting, Scottish representation was always numerically smaller than English. Scottish views... seemed always to be viewed by the English as inferior and we were just troublemakers. There was no support from Welsh or Irish delegations who, certainly in the view of Scots, seemed just to accept what the English said and 'it would be all right'. So we always felt isolated and on the defensive...

<sup>98</sup> NAS, CMB 1/9, CMB Minutes, 19 December, 1974, p 1.

<sup>99</sup> NAS, CMB 1/9, CMB Minutes, 18 July, 1974, p 3.

<sup>100</sup> CMB Report, 31 March, 1975, p 2.

<sup>101</sup> NAS, CMB 1/9, CMB Minutes, 17 April, 1975, p 1.



It wasn't just the Board...the forum didn't matter. We did feel that we were ignored and that forced us on to the defensive. There was no doubt about it... This is really an aside. One person to whom Scotland, Wales and Ireland [have] great need to be grateful in the setting up of the UKCC was Enoch Powell. He said, 'If you have a Council, you have to have equal representation'. And he fought for it...I think that a lot of the agonising that went on with the setting up of the UKCC was because of the fear of being taken over. I don't think that that would happen now. I think people [who are] the leaders of nursing and midwifery in Scotland now are much more confident than we were. They're much more confident and they're more confident of a Scottish identity.<sup>102</sup>

The issue of Scottish, along with professional, identity was therefore important. It influenced the argument and was intensified by the contemporary political debate on devolution. The 1970s was a decade of increasing discussion of legislation about devolution for Scotland and Wales. It seemed inappropriate for the Government to be discussing devolving power and at the same time the recommendations of the Briggs Committee were to centralise power. Ian Sharp of the SHHD noted that if the Briggs legislation came before Parliament about the same time as legislation on Scottish devolution 'it would be well-nigh impossible for Scottish ministers to defend' the handing over 'to a Great Britain body functions over which Scotland has exercised its own statutory control for so long'.<sup>103</sup> This was another argument in favour of decentralising power from the proposed Central Council.

Before the 1979 Nurses, Midwives and Health Visitors Act was passed representatives of the CMB took part in the Briggs Co-ordinating Committee and Working Groups, drafting the 'Briggs Bill' and deciding on the committee structure of the Central Council and the National Boards. This included statutory midwifery committees at both Council and Board levels and very much stronger National Boards

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<sup>102</sup> LR, 41 [120].

<sup>103</sup> Letter from I Sharp, SHHD, to R B Hodgetts, DHSS, quoted in Davies and Beach, *Interpreting Professional Self-Regulation*, p 14.

than the Briggs Committee had envisaged.<sup>104</sup> Lobbying by professional groups continued right up until the last phase of the legislative process leading to the Act, with midwives ‘arguably, the most successful, gaining increased authority for the Central Council’s Standing Midwifery Committee’.<sup>105</sup> Margaret Auld agreed that the Midwifery Committee had power and used it effectively.

Some weren’t happy. Some people felt very threatened by ... [the proposed change. They] were concerned that the quality of care would be less, standards would fall and that with a Committee they wouldn’t have the same authority as the Board had...but... that hasn’t been proven correct. In fact this committee has had huge powers.<sup>106</sup>

The Nurses, Midwives and Health Visitors Act received the Royal Assent on 4 April 1979 and established the UKCC and four National Boards which took over the functions of nine bodies including the CMBs, firstly in ‘shadow’ form and then officially, on 1 July, 1983.<sup>107</sup> The principal functions of the UKCC were: to prepare and maintain a register; and, to establish and improve standards of training and professional conduct.<sup>108</sup> Each country of the UK had a National Board comprising thirty-five members in Northern Ireland and forty-five members in the other countries. The functions of the National Boards covered: the provision of educational courses and their examinations; collaboration with the UKCC in the promotion of improved training methods; and, investigation of alleged misconduct before recourse to the UKCC for further proceedings.<sup>109</sup> Thus, as far as the CMB was concerned, the UKCC and the NBS took over all of its functions. Each body had a statutory Midwifery Committee as shown in

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<sup>104</sup> CMB Report, 31 March, 1978, p 3

<sup>105</sup> Davies and Beach, *Interpreting Professional Self-Regulation*, p 17.

<sup>106</sup> LR, 25 [105].

<sup>107</sup> Davies and Beach, *Interpreting Professional Self-Regulation*, p 24.

<sup>108</sup> 1979 Nurses, Midwives and Health Visitors Act, Chapter 36, Section 2; Davies and Beach, *Interpreting Professional Self-Regulation*, p 25.

<sup>109</sup> 1979 Act, Section 6.

Table 5.1, with a majority of midwives, for consultation on all matters pertaining to midwifery.

Originally the Government wanted to delay for twelve months a decision about introducing the necessary subordinate legislation setting up the Central Council and National Boards. However in view of the strength of feeling against this proposal, the Government agreed to set up the National Boards on 15 September 1980 and the Central Council on 1 November 1981, with the existing statutory bodies continuing for two or three years after the new bodies were established.<sup>110</sup> Thus, the CMB maintained a high profile, liaising with the new bodies, attending meetings and ensuring that midwifery interests in Scotland continued to be heard at the highest level.<sup>111</sup>

The NBS appeared keen to utilise the experience of Board members. In September 1982, Board Chairman Miss Mary M Turner and Miss M L Brown, both practising midwives, became members of the National Board for Scotland (NBS) shadow Midwifery Committee. Miss Annie Grant, Board Education Officer, was an observer on the Midwifery Committee and her status was recognised further when she was nominated to serve on the NBS Working Group on Continuing Education.<sup>112</sup>

Statutory care for midwifery in Scotland moved from the CMB into the hands of the UKCC and the NBS on 1 July 1983. The move from the old statutory bodies to the new was not trouble free. The events of the previous thirteen years since the setting up of the Briggs Committee precluded that. After the implementation of the 1979 Act, it was

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<sup>110</sup> NAS, CMB 1/9, CMB Minutes, 20 September 1979, p 4; CMB Report, 31 March, 1981, p 3; CMB Report, 31 March, 1980, p 3.

<sup>111</sup> CMB Report, 31 March, 1981, p 4; NAS, CMB 1/9, CMB Minutes, 19 March, 1981, p 2; NAS, CMB 1/9, CMB Minutes, 18 June 1981, p 1; NAS, CMB 1/9, CMB Minutes, 24 April, 1980, p 1; NAS, CMB 1/9, CMB Minutes, 18 September, 1980, p 1.

<sup>112</sup> CMB Report, 31 March, 1982, p 3; NAS, CMB 1/9, CMB Minutes, 29 April, 1982, p 1.

clear that there was conflict, insecurity and mistrust between the different professions, with varying nationalities and traditions, now pulled together under one Act. Overcoming these divisions was one of the biggest challenges to face the UKCC and the National Boards.<sup>113</sup>

## **Conclusion**

This chapter has examined aspects of the CMB's work from 1960 to 1983, the last years of the CMB's existence. During this time the Board appeared to increase its effectiveness both administratively and in its ability to promote the interests of midwifery.

The beginning of this period saw the Board establish an Executive Committee which expedited decision-making and raised efficiency. One of the first achievements of the Executive Committee was to organise the appointment of an Education Officer to the Board. Here was a new post with wide responsibilities. This salaried officer took on duties previously performed by Board members, inspected training institutions, advised on all educational matters and reported to the Board. Through this, the work of the Board was publicised and its status amongst midwives and other professionals raised.

The CMB's struggle with the loss of midwifery matrons, and an accompanying perceived loss of status with diminishing career prospects appeared at times to be a one-sided battle. Time and again the members protested against changes in midwifery management and teaching where, as in the change of management at VOL, events conspired to reduce the autonomy and status of midwives inadvertently, and the Board found there was no going back. Yet the Board's views could be ambiguous. When given

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<sup>113</sup> Davies and Beach, Interpreting Professional Self-Regulation, p 18.

a chance to make comment, for instance on the issue of integration of midwifery, the CMB appeared to recommend that midwives should have the authority that was theirs by statute, yet under the overall control of a consultant obstetrician. The CMB wanted midwives to be in the team but not with equal status.

During its last years the CMB, facing extinction, appeared to champion midwives more than ever before. It had an excellent Education Officer in Annie Grant. It also had from 1977 to 1983 two dedicated midwife Chairmen, Sheelagh Bramley and Mary Turner. Margaret Kitson, remembered working with them both on the Board.

Miss Bramley was a great champion of midwives. She upheld what she saw as the rights of the profession against all odds and against all opposition and she was determined that midwifery should be seen as, not only a profession in its own right, but as a profession that could produce managers and teachers who could stand beside their nursing colleagues and not in any inferior capacity to them. And she...really tried...very hard to ensure that midwives would always remain independent and [would] not be subservient to nursing, ever.<sup>114</sup>

Latterly, midwife members of the CMB increased in numbers due to electing bodies choosing them instead of lay members.<sup>115</sup> Earlier, being a midwife on the CMB dominated by non-midwives was not easy for new members. Margaret Kitson remembered how Mary Turner in the Chair changed things.

I was elected by the midwives [in 1973]...I felt then I had a great responsibility to speak for the midwives but it was really very very difficult because there was a patronising attitude amongst the people who had been on the Board for a long time. There was a very definite, 'we know best'. There wasn't encouragement to speak up and only gradually did that change. And the change really came when Mary Turner...became the Chairman of the Board [in 1978]...She changed it in the most professional...and ladylike way, without being abrasive, without being confrontational but by being very positive and just always stating her case very clearly, listening to argument, but by just in a very gentle way, changing the whole atmosphere in the Board so that it became much more possible for people to express their views.<sup>116</sup>

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<sup>114</sup> LR, 41, [120].

<sup>115</sup> See chapter 2, p 53.

<sup>116</sup> LR, 41 [120].

The CMB might have lost the battle for its existence and thus for the independence of midwives in Scotland, for what it saw as the right form of education for midwives and for midwives' right totally to manage themselves clinically and educationally. Yet the UKCC Midwifery Committee for which Margaret Auld fought became a reality. Through the intervention of the CMB and others, the planned National Boards were made stronger educationally and clinically for all the professions involved. Particularly for midwifery, the NBS, like the other National Boards, was strengthened by a statutory Midwifery Committee to consult and advise before any changes in midwifery could be made.

## **Part II**

### **Practising midwives**

## Chapter 6

### Antenatal care

Before the beginning of the twentieth century, antenatal care as we know it today was non-existent. As pregnancy was viewed as a normal event and nature was considered to need no assistance, advice offered to pregnant women was confined to suggestions on a recommended lifestyle.<sup>1</sup> Since the early twentieth century the ‘normal event’, pregnancy, has become increasingly under the care (or jurisdiction) of members of the medical profession developing the specialty of obstetrics. In The Captured Womb Ann Oakley argued that obstetricians needed to perform antenatal care primarily as a means of extending and keeping alive their developing specialism.<sup>2</sup> This is akin to the theory that medical practitioners have claimed that medical knowledge was their sole property and that medicine cannot be understood except by those who practise it.<sup>3</sup> Thus, exclusivity of knowledge made safe the profession or specialty for its members.

By the beginning of the twentieth century those in the developing specialty of obstetrics could not claim exclusivity of knowledge about what was happening *in utero*. As women held the key to the information, early diagnosis of pregnancy, assessment of the expected date of delivery, the date of first feeling fetal movements and the starting time of labour were all difficult for an outsider to judge. As late as 1914, for example, Dr JK Watson commented on the difficulty even ‘experienced medical men’ had in

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<sup>1</sup> A Oakley, The Captured Womb, (Oxford: Basil Blackwell Publisher Ltd., 1984), pp 13 and 25.

<sup>2</sup> Ibid, p 2, quoted from W Arney, Power and the Profession of Obstetrics, (London: University of Chicago Press, 1982), p 51.

<sup>3</sup> Ibid, p 3.



diagnosing pregnancy.<sup>4</sup> Also, as women were not in the habit of attending doctors or midwives for antenatal care, development of knowledge about pregnancy was slow.

This chapter examines aspects of antenatal care in Scotland between 1916 and 1983, the years of the existence of the CMB for Scotland. It explores the beginning of antenatal care and clinics, and midwives' involvement from 1916, showing how the relevant Acts and CMB Rules restricted midwives' practice. It discusses antenatal care in urban and rural areas and why, even where a LA provided clinics, some mothers did not attend. I also examine changes in antenatal care in the latter half of the twentieth century including the gradual integration of care between community and hospital which both mothers and midwives found more satisfactory.

### **The dawning of organised antenatal care**

In the early twentieth century maternal and infant mortality rates were very high.<sup>5</sup> For the years 1901-1905 the Infant Mortality Rate (IMR) in Scotland was 120 per 1,000 live births and the Maternal Mortality Rate (MMR) was 5.1 per 1,000 live births. The latter rose to 6.1 in 1915<sup>6</sup> and remained around that level until the mid-1930s.<sup>7</sup>

Correspondingly, the Boer War (1899-1902) demonstrated the low level of fitness of enlisted men. This prompted the Government to establish in 1902 an

Interdepartmental Committee to investigate the Physical Deterioration of the Population.

The Committee's Report in 1904 stressed that the high IMR made infant and child

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<sup>4</sup> Watson, J K, *A Complete Handbook of Midwifery*, 3<sup>rd</sup> ed, (London: The Scientific Press Limited, 1914), p 64.

<sup>5</sup> Oakley, *The Captured Womb*, pp 32-33; also see chapter 3, p 80 for further discussion on maternal mortality.

<sup>6</sup> H P Tait, 'Maternity and Child Welfare: The Origins and Progress of the Maternal and Child Health Services', in G McLachlan, ed *Improving the Common Weal*, (Edinburgh: Edinburgh University Press, 1987), p 416.

welfare very important and argued that improvement would come, not from increased medical care of pregnant woman, but from a less costly option: the education of mothers regarding the care of their children.<sup>8</sup>

Not everyone agreed, including an Edinburgh obstetrician and pioneer of antenatal care, John W Ballantyne who thought attention should be turned to pregnancy. 'Ballantyne's dream' saw a day when science and technology would give obstetricians the power 'to extract every fetus from the womb live and healthy' and to predict the time of birth by inducing labour. In 1901 he argued for a 'Pro-Maternity Hospital', an in-patient establishment for pregnant women, primarily for the understanding and treating of 'morbid' pregnancies. Through his influence, the first antenatal bed in Britain, soon emulated elsewhere, was opened in Edinburgh in 1901. Ballantyne's main interest was not healthy pregnant women, but pregnancy itself. Any woman in his antenatal bed could add to the knowledge of pregnancy, its physiology, pathology and effects of treatment.<sup>9</sup>

But there was another side to caring for pregnant women which put wellbeing of women first. When Dr James Haig Ferguson, also of Edinburgh, a colleague of Ballantyne's and a future CMB chairman, helped to set up a home for unmarried mothers in late pregnancy at 4 Lauriston Place, Edinburgh in 1899, he found 'that rest, good food, healthy surroundings and medical supervision' gave improved outcomes with fewer pre-term births, higher birthweights and lower neonatal mortality'.<sup>10</sup> He stressed that an obstetrician's first duty was to preserve maternal life and health, and therefore all

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<sup>7</sup> Hansard, Commons, Vol 319, 28 January, 1937, Cols 1099-1155.

<sup>8</sup> Oakley, *The Captured Womb*, p 36.

<sup>9</sup> *Ibid*, pp 47-49, quoted from: J Ballantyne, 'Inaugural Address on the future of Obstetrics', *Trans Edin Obst Sc* 32, (1906-07) pp 3-28; M Tew, *Safer Childbirth? A critical history of maternity care*, 2<sup>nd</sup> ed, (London: Chapman and Hall, 1995), p 88.

<sup>10</sup> *Ibid*, p 89.

pregnant women should have antenatal 'supervision'.<sup>11</sup> In 1915 his antenatal clinic 'for infant and prematernity consultations' began at Edinburgh Royal Maternity Hospital and, although ill-appointed, gradually found favour.<sup>12</sup>

### **The development of antenatal care**

From the time of Ballantyne and Ferguson, the provision of antenatal care increased, albeit slowly. It was aided by the development in Scotland of 'Schemes of Maternity and Child Welfare' after the 1915 Notification of Births (Extension) Act. These gave LAs the power and opportunity to devise antenatal clinics (or maternity centres) of varying sizes and types, often by arrangement with an existing institution or society.<sup>13</sup> Antenatal care was also expedited by the 1918 Maternity and Child Welfare Act which enabled municipal authorities to fund salaried midwives and health visitors, free or cheap food for mothers and children, antenatal clinics and day nurseries. The primary purpose of antenatal clinics was free medical supervision and advice for uninsured women.<sup>14</sup> In time, clinics became a source of health education and 'mothercraft' as well. There was a lessening of voluntary activity and an increase in municipal clinic antenatal care which eventually dominated care in pregnancy for the next forty years until hospital-based care became the controlling element of antenatal provision.<sup>15</sup> Initially, there was a short-lived suggestion, that a woman should be obliged to notify her pregnancy, thus raising the

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<sup>11</sup> Oakley, *The Captured Womb*, p 51; J Sturrock, 'Sir James Young Simpson and his Memorial Hospital', in *Edinburgh's Infirmary*, (Edinburgh: Lammerburn Press Ltd, 1979), p 37.

<sup>12</sup> W L MacKenzie, *Report on the Physical Welfare of Mothers and Children*, Vol.3, Scotland, (Dunfermline: The Carnegie United Kingdom Trust, 1917), p 51.

<sup>13</sup> *Ibid*, p 564; see chapter 7, p 226 for further discussion on maternity schemes.

<sup>14</sup> Oakley, *The Captured Womb*, p 56; the Montgomery Report, para 66.

<sup>15</sup> Oakley, *The Captured Womb*, pp 54-55.

number attending for antenatal care. However, the hope was that women, on learning of the benefits of antenatal care, would come to the clinics without coercion.<sup>16</sup>

In many areas, especially in towns and cities such as Glasgow, antenatal work in municipal clinics increased in the 1920s, staffed by public health medical officers, nurses, midwives and/or health visitors. In Glasgow in 1926, 988 'cases' attended clinics which had been established at Bridgeton, Cowcaddens and Govan with another three clinics financed by the Local Authority opening by the end of the year in Partick, Hutchesontown and Maryhill.<sup>17</sup> To have antenatal clinics like these 'wherever there was a sufficient concentration of population to justify them' was in line with Government recommendations of the day, along with further development of hospital antenatal clinics.<sup>18</sup> However, quality of care was an early issue. In 1933 J M Munro Kerr, Professor of Midwifery at Glasgow University, wrote that although antenatal care was a topical issue, there was a lack of understanding about what was adequate, and the perfunctory care which was sometimes seen was unacceptable.<sup>19</sup>

Many mothers did not attend clinics or seek medical advice. In some areas there were no clinics within easy reach, emphasising the unevenness of antenatal care across Scotland. In St Andrews in 1926 inadequate arrangements prompted the Town Council to start a new antenatal clinic for 'necessitous and other mothers', with local doctors providing services free of charge and midwives instructed to encourage mothers who

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<sup>16</sup> MacKenzie, Report on the Physical Welfare of Mothers and Children, p 49.

<sup>17</sup> Corporation of Glasgow Public Health Department, Scheme for Maternity and Child Welfare, (Glasgow: The Committee on Health, 1926), pp 32 and 23. Health visitors in that situation were required to have the CMB certificate.

<sup>18</sup> Departmental Committee of the DHS, Report on Puerperal Morbidity and Mortality, the Salvesen Report, (Edinburgh: HMSO, 1924), p30.

<sup>19</sup> Munro Kerr, Maternal Mortality and Morbidity, p 175.

could not afford a doctor to attend two or three times in the pregnancy.<sup>20</sup> Even in areas where antenatal clinics were in operation, only a small proportion of mothers attended. For example, in Glasgow in the years 1926-1930 inclusive, the district service of the GRMH booked 18,828 patients. Of this number, only twenty-seven per cent sought or received any kind of antenatal care, and of these only ten to fifteen per cent attended the antenatal clinic regularly.<sup>21</sup> The first reference to antenatal care in a CMB Annual Report was in 1926. Here, the MOH for Ayr reported that often in emergency labours the mother had received no previous care and called for further antenatal facilities.<sup>22</sup> By the following year he appeared more satisfied and said 'the increasing attendances at the antenatal clinics show that the work is advertising itself'.<sup>23</sup>

However, municipal clinics did not give mothers continuity of care from ante, to intranatal. The 1935 Douglas and McKinley Report recommended more continuity or, at least, transferring of records from the clinic to the midwife attending the confinement.<sup>24</sup> Two years later, the 1937 Maternity Services (Scotland) Act required LAs to coordinate maternity services professionals in Scotland.<sup>25</sup> This plan put maternity services, not just clinics, mainly in the hands of LAs and attempted to achieve a greater spirit of team-working. However, not all LAs achieved co-ordination (the Act was not adopted in Glasgow and Dundee), and LA antenatal clinics were still mainly staffed by public health doctors.<sup>26</sup>

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<sup>20</sup> NAS, CMB 2/10-14, CMB Report, 31 March 1927, p 7.

<sup>21</sup> Oakley, The Captured Womb, p 80.

<sup>22</sup> NAS, CMB 2/10-14, CMB Report, 31 March, 1926, p 7.

<sup>23</sup> NAS, CMB 2/10-14, CMB Report, 31 March, 1927, p 6.

<sup>24</sup> DHS, Scientific Advisory Committee: Clinical Sub-Committee, C A Douglas, and P L McKinley, Maternal Morbidity and Mortality in Scotland, (Edinburgh: HMSO, 1935), p 25.

<sup>25</sup> 1937 Maternity Services (Scotland) Act, 1, 1-11.

<sup>26</sup> DHS, Scottish Health Services Council, Maternity Services in Scotland, the Montgomery Report, (Edinburgh: HMSO, 1959), para 12; Ibid, para 62.

The use of municipal antenatal clinics continued with varying levels of success in urban areas of Scotland until the implementation of the NHS Acts in 1948 brought further change.<sup>27</sup> The NHS's tripartite structure dispelled the attempt of the 1937 Maternity Services (Scotland) Act to encourage professionals in the maternity services to work as a team. Then, as already mentioned in chapter four, the GP became the first point of contact for most pregnant women instead of the midwife and had a greater part to play than ever before in antenatal care. Simultaneously, the demand for hospital births increased and the use of hospital antenatal clinics rose correspondingly, particularly as some women, to be sure of a hospital bed for delivery, by-passed the LA clinic and went directly to the hospital clinic. LA clinics, caught in the competition for patients between GP and hospital, became significantly less popular.

The demand for LA clinics fell further in the 1950s. In 1956 in response to the Guillebaud Committee's comments on the post-NHS Act confused state of the maternity services, the Government appointed the Montgomery Committee to review and report on the maternity services in Scotland.<sup>28</sup> This Committee reported in 1959 and recommended that a GP (with extra training and designation as GP obstetrician) should be regarded as the co-ordinator of maternity services and it should be his responsibility to provide facilities for the mother. If a woman went first to her LA antenatal clinic, unless she objected, the staff at the clinic should inform the GP.<sup>29</sup> Also, the Committee recommended that LAs should instruct midwives in their employ to urge women wishing

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<sup>27</sup> The NHS and its effect on the maternity services is discussed further in chapter 4, p 133.

<sup>28</sup> J Towler and J Bramall, *Midwives in History and Society*, (London: Croom Helm. 1986), p 251; NAS, CMB, 1/7, *CMB Minutes*, 18 October, 1956, p 2.

<sup>29</sup> *Montgomery Report*, paras 67-74.

to book them to make arrangements with the GP.<sup>30</sup> There was a need for antenatal hospital accommodation and the Committee recommended, along with more maternity beds to cope with the rising demand, the specific provision of eight antenatal beds per 1000 births per year. All of these factors contributed to the decline of LA clinics and by 1958 across Britain, attendances had dropped to fifteen per cent.<sup>31</sup>

Falling attendances meant that fewer mothers received what became an important feature of municipal clinics: parentcraft and health education.<sup>32</sup> To rectify this the Montgomery Committee recommended that GP obstetricians and hospital obstetricians should be able to utilise the municipal clinic premises and the services of their staff to give a comprehensive service of medical care, supervision, health education and guidance'.<sup>33</sup> However, from the 1950s the increased infiltration of LA clinics by consultant obstetricians and the rise in GP antenatal care corresponded with the demise of LA clinics as they were originally conceived. At the same time there was a rise in hospital clinics, hospital births and number of consultant obstetricians.<sup>34</sup>

### **Where did the midwife come in?**

Examination of the early days of antenatal care gives little evidence of the midwife's place in this field. Although the 1915 Midwives (Scotland) Act provided for the CMB to make Rules for certified midwives to follow, it made no reference to antenatal care. In the first complete set of Rules published by the CMB on 26 August 1916, there were no

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<sup>30</sup> *Ibid*, para 77.

<sup>31</sup> Oakley, *The Captured Womb*, p 138.

<sup>32</sup> *Montgomery Report*, para 92.

<sup>33</sup> *Ibid*, para 95.

<sup>34</sup> Oakley, *The Captured Womb*, p 218.

specific references to antenatal care of women, and references to pregnancy were few.<sup>35</sup>

The Rules of the Board required that a pupil midwife should be examined in:

Pregnancy

1. Its hygiene;
2. Its diseases and complications including abortion ;  
both in relation to a) the mother and b) the unborn child.<sup>36</sup>

Rules E, covering midwives' practice, stated the need for a midwife to summon medical assistance in all cases of illness or abnormality, of a mother and child during pregnancy, labour or lying-in.<sup>37</sup> More specifically, during pregnancy, a midwife had to call for medical aid when there was 'any abnormality or complication, such as: deformity or stunted growth; loss of blood; abortion or threatened abortion; excessive sickness; puffiness of hands or face; fits or convulsions; dangerous varicose veins; purulent discharge; sores of the genitals'.<sup>38</sup> These Rules, therefore, acknowledged that midwives had contact with pregnant women. However the Rules did not specify how the midwife should practise and how or what pupil midwives should be taught.

In the 1920s the length of training was extended in both Scotland, and England and Wales, to twelve months for 'untrained women' and six months for trained nurses.<sup>39</sup> This included specific antenatal training and examination. With more women attending antenatal clinics in the 1920s the Board acknowledged that here was an excellent opportunity for education.<sup>40</sup> A pupil midwife's objective was to know how to 'supervise' at least twenty pregnant women in preparation for an examination which included 'the physiology, diagnosis, and management of normal pregnancy, the hygiene and care of the

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<sup>35</sup> NAS, CMB 4/2/10, Schedule. CMB for Scotland, Rules framed under Section 5 (1) of the Midwives (Scotland) Act, 1915 (5 and 6 Geo V c 91), 26 August, 1916.

<sup>36</sup> NAS, CMB Rules, 26 August, 1916, Rules C, p 5.

<sup>37</sup> Ibid, Rules E, p 10.

<sup>38</sup> Ibid, Rules E (2), p 10.



pregnant woman and the unborn child, including the examination of the urine'.<sup>41</sup> With regard to antenatal midwifery practice, the new Rules E stated

When engaged to attend a confinement the midwife must, wherever possible, interview her patient at the earliest opportunity to inquire as to the course of the present and any previous pregnancies, confinements, and puerperia, both as regards mother and child, to examine the urine, and to advise as to personal and general arrangements for the confinement.<sup>42</sup>

Thus there were developments in the level of knowledge of pregnancy and antenatal care required for the CMB examination. However it was difficult to put this knowledge into practice. The Rule Books from 1918 onwards informed midwives of LA provision of 'maternity centres' and said, 'the midwife should advise the patient to avail herself of such help', thereby denying most midwives (booked to deliver the baby) the opportunity of performing normal antenatal care.<sup>43</sup> Thus by 1930, antenatal care was part of midwifery training and examination and some midwives worked in antenatal clinics funded by LAs in large towns and cities in Scotland. But there is no evidence that the CMB encouraged midwives to perform antenatal care by themselves either in clinics or in mothers' homes.

Further evidence of midwives' lack of involvement in antenatal care exists in the CMB Rules. Midwives had to keep a register containing details of their clients, abnormalities found and whether a mother had gone as advised to the clinic or a medical officer.<sup>44</sup> A form of Register of Cases was included in the Rule Books from 1918.

However, until 1931 the only relevant antenatal details requested were 'Date of expected

<sup>39</sup> NAS, CMB 1/3, CMB Minutes, 27 June, 1924, Vol 9, p 27.

<sup>40</sup> NAS, CMB 1/3, CMB Minutes, 28 May, 1925, Vol 10, p 21.

<sup>41</sup> CMB Rules, 1926, p 10; *Ibid*, p 12.

<sup>42</sup> *Ibid*, p 15.

<sup>43</sup> CMB Rules, 1918, p 16.

<sup>44</sup> CMB Rules, 1931, p 35.

confinement' and 'Number of previous labours and miscarriages'. It was very much a register of women a midwife had looked after during labour and birth. This register developed into a two page document in 1931, the first page of which was a 'History of Pregnancy' requiring more antenatal details than hitherto.<sup>45</sup> This format remained until 1968 when an updated form included a record of antenatal visits performed by the midwife.<sup>46</sup> The apparent step forward in 1931 was cancelled out in the same Rule Book where the Rule about 'advising' a mother to go to the antenatal clinic became imperative.

The midwife must advise the patient to seek medical advice or to avail herself both before and after the birth of the child of the help provided by the Local Authorities through their health visitors, Maternity centres and Child Welfare Centres, and, in particular, should urge her to submit herself for medical examination at as early a stage in her pregnancy as possible.<sup>47</sup>

If a mother did not co-operate, the midwife had to notify the LSA on the official 'Form of notification of patient's failure to follow advice'.<sup>48</sup>

Thus, the CMB Rules suggest that midwives had little authority in the field of antenatal care in Scotland even for mothers undergoing a normal pregnancy. Indeed, Munro Kerr underlined this when he indicated that only midwives working in/with LA antenatal clinics should provide antenatal care. This would be the 'most efficacious and economical arrangement'.<sup>49</sup> There, midwives would work under constant surveillance of public health doctors. Munro Kerr acknowledged that to use midwives in antenatal clinics would be a less expensive option than the 'prohibitive' cost of an all-medical service but he did not want them to work autonomously. Midwives booked for a birth could also attend clinics with women, and the MOH for Ayr encouraged this practice, with the

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<sup>45</sup> Ibid.

<sup>46</sup> CMB Rules, 1968, pp 33-35.

<sup>47</sup> CMB Rules, 1931, p 17.

<sup>48</sup> Ibid, p 34.

cautious rider, 'I am glad to report that the standard of knowledge and practice is improving... There is plenty of work for the skilled and capable midwife.'<sup>50</sup> Midwives doing this worked under supervision and sometimes attended lectures supplied at the clinics particularly for the bona fide midwives who had not received formal training. However many midwives sent mothers to clinics but did not do antenatal care themselves.<sup>51</sup>

In England, midwives seemed to be more independent. Towler and Bramall, examining the CMB (E&W) Rule Book for 1928, show that in England and Wales it appeared to be the norm for a midwife to have considerable input into antenatal care.

At this time it was by no means a regular occurrence for a mother to see a doctor in the antenatal period, and although it was suggested that a mother should see a doctor in early and late pregnancy, it was recognised that this would encroach 'upon the duties of the midwife in the antenatal sphere'.<sup>52</sup>

A Government committee reporting in 1948 on Maternity in Great Britain, a cross-Britain survey of mothers who gave birth during the week 3-9 March 1946, further emphasised the differences in who 'supervised' antenatal care in different parts of Britain. Mothers said they received care from LAs including clinics, GP schemes and midwives in clinics and at home. Some mothers received care privately from 'specialists', practitioners, [GPs] and midwives. Many mothers attended one category and were sent to another. When discussing GP schemes for antenatal care the Report stated that

In Scotland... medical practitioners take a much more active part in the antenatal services than in England and Wales. Thus, working either privately or under municipal schemes, they supervise fifty three per cent of Scottish expectant

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<sup>49</sup> Munro Kerr, Maternal Mortality and Morbidity, p 300.

<sup>50</sup> NAS, CMB 2/10-14, CMB Report, 31 March, 1927, p 6.

<sup>51</sup> Ibid; NAS, CMB 2/10-14, CMB Report, 31 March, 1926, p 7: The 1926 CMB Rule Book stipulated antenatal care of women as part of a pupil midwife's curriculum. Midwives who trained earlier and older bona fide midwives would not have received this.

<sup>52</sup> Towler and Bramall, Midwives in History and Society, p 216.

mothers as compared with thirty six per cent of English and thirty four percent of Welsh.<sup>53</sup>

There appeared, therefore, to have been a variety of areas where midwives in Scotland practised antenally, most of them in subservient roles. They worked in municipal antenatal clinics under the guidance of public health doctors and in women's homes in a municipal midwifery role; they worked in the antenatal clinics of hospitals similar to the one which was started by Dr Haig Ferguson, again under supervision of doctors. Many midwives working on the district, booked mothers for delivery, interviewed and advised them to attend the clinics in accordance with the CMB Rule Book; in most cases they did not do the antenatal care themselves, and then delivered the mother at home.

### **Variations in provision and uptake**

In the 1920s and 1930s in the cities and towns of Scotland, the amount and type of antenatal care offered varied widely. Even where it was offered it was often not taken up and some oral history testimonies I collected show reasons for this. One reason was lack of provision combined with poverty. For example, Ann Lamb, in midwifery training in Edinburgh in 1927-28, said, 'There was no antenatal care. Some people didn't even know they were having a baby till they delivered. Poverty was very bad, very, very bad, but cheery people.'<sup>54</sup> The link Ann Lamb makes between poverty and the lack of antenatal care was reinforced by Molly Muir who did midwifery training in the 1930s in Edinburgh

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<sup>53</sup>G Cumberlege, *Maternity in Great Britain*, (London: Oxford University Press, 1948), pp 22-47.

<sup>54</sup>Oral testimony. For details of the oral interviews conducted in relation to this research, see Appendix 4. LR, 19 [47].

and had district experience in Gorgie, one of the poorest areas of Edinburgh. She also made a link between the poor area and a lack of clinics.

Working in Gorgie at that time there were very few antenatal clinics. Sometimes when the mother went into labour you found it was a face presentation. That was the worst I ever came across. Other things happened that you didn't know anything about until the mother was in labour. There was very little antenatal care.<sup>55</sup>

Even though mothers had little or no antenatal care, it was usual to make preparations for the birth.

I think they had all made arrangements even though there were so few antenatal clinics. I think that when somebody was pregnant and they knew they were going to get the midwife in for the delivery, it was arranged quite a long time in advance. Then, when the time came she would phone the hospital [for a midwife] from a public telephone.<sup>56</sup>

Yet poverty combined with the lack of provision of antenatal care in some areas was not the only reason which prevented mothers from receiving it. Margaret Foggie, a South African who trained as a midwife in 1934 in GRMH, pointed out that many mothers lacked the incentive to do anything for the expected baby.

Unemployment was terrible and there was such a kind of despair about it. Glasgow Corporation produced a layette for the new baby if the woman had been to the antenatal clinic and got a form saying she was pregnant. They had to go and get this layette which was fine for the baby and very often they hadn't even bothered to go and do it. There was such a kind of feeling of I don't know what – apathy. And even in some of the new tenements that had been built where there were baths and things, they didn't use the baths. I actually have seen coal in the bath. It was very sad. I had never seen people living like that. It was awful, absolutely awful.<sup>57</sup>

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<sup>55</sup> LR, 13 [46]; A face presentation, giving a long and difficult labour, could be picked up antenatally on palpation.

<sup>56</sup> Ibid.

<sup>57</sup> LR, 22 [50]; Corporation of Glasgow, Report of the Medical Officer of Health, City of Glasgow, 1934, p 80. Layettes supplied by the Corporation were also known as 'maternity bundles'. In 1934 in Glasgow, 1,131 bundles were supplied.

Munro Kerr also used apathy amongst mothers as an important reason for not looking after themselves during pregnancy. Drawing on the Report of a Government Departmental Committee presented at a Conference on Infant Mortality in August 1913, he wrote, ‘the patient herself is often her own worst enemy, whether from ignorance, apathy, ill-health, or prejudice’.<sup>58</sup>

Sometimes, pregnancy was considered a secret. This sometimes happened in Shetland where the picture of antenatal care in the 1920s and 1930s depended on location. Chrissie Sandison, a local historian, now in her eighties, recollected:

The women in the early twenties, they never had any examinations or care beforehand. I remember Jimmy’s mother telling me about when she was young. When she was having her children it was kept a secret until she was sure... then the mother who was expecting would speak to some old neighbour, somebody she knew would help and they kept it a secret – although they would have been asked they never told anybody... Lots of those expectant mothers of all those years ago... had no pre-natal examinations. An expectant mother *at da faain-fit* which meant getting near to the time of delivery, would have ‘spoken for’ a midwife. All else was left to Mother Nature. Sometimes all went well, sometimes not.<sup>59</sup>

Margaret MacDonald, a Green Lady in Glasgow in 1947 agreed that mothers did not talk about their pregnancies and suggested this as a reason for non-attendance at clinics.

Women in these days were different from women today. Everything today is open and above board and people talk about everything. From sex, from conception right up to delivery. They talk about all sorts of things. In these days we didn’t. It was all kept under wraps. Nothing was open and above board... They didn’t trust people to know about them. They didn’t want to – my mother didn’t do it [go to clinics] so I’ll not do it. That kind of thing. That was the attitude.<sup>60</sup>

Mima Sutherland, a midwife from Unst, the most northerly island in Shetland, gave a different picture. She trained as a midwife in Aberdeen in 1931 in Aberdeen Maternity

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<sup>58</sup> Munro Kerr, *Maternal Mortality and Morbidity*, p 177.

<sup>59</sup> LR, 6 [61].

<sup>60</sup> LR, 44 [125].

Hospital (at that time near Gordon Barracks). She eventually returned to Unst in Shetland to practise.

In my time the mothers were all supervised. You could see them and they could get their urine tested, you see, and then you would know if they needed to see the doctor. They were seen regularly. Then you would wait for them to send for you [when they went into labour].<sup>61</sup>

Mima Sutherland not only indicates the existence of antenatal supervision on Unst but also implies that if the mother's urine were satisfactory, the midwife would carry on with the mother's antenatal care.

One difference between the two Shetland contributors is geographic. Chrissie Sandison was reporting the situation on the mainland of Shetland, an island community but big enough to be broken up into other communities with a capital town, Lerwick, and other villages and rural communities. Mima Sutherland was midwife to a very small island community and this probably contributed to her ability to give care. In a similar way to Mima Sutherland on Unst, in the Outer Hebrides, a midwife (who has asked to remain anonymous) seemed to have a big input into antenatal care of women.

I did the antenatal care all the time and sometimes on the first visit the mother would say, 'There's another one on the way but don't tell the doctor yet'. I would say, 'But I must tell the doctor'. The doctor went after you notified him. They didn't book early. After that we visited fortnightly, and weekly for the last month. We were on call when they came to term.<sup>62</sup>

In areas of Scotland where uncertificated midwives or howdies worked, they sometimes moved in with the family, not to provide formal antenatal care, but to help with the household work as Doddie Davidson did in Aberdeenshire in the 1940s. 'I went and lived in the hoose afore the bairns were born. Usually they were needin some help

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<sup>61</sup> LR, 5 [56].

<sup>62</sup> LR, 23 [99].

especially fan there wis some little anes.’<sup>63</sup> Annie Kerr working as a howdie in the Dumfries area, also in the 1940s said the same. ‘I went a wee while before the baby wis born. Not as much as a couple o weeks...I wis with them and did everything that wis to be done ye know, to give her a rest. That workit in fine.’<sup>64</sup>

In the King Street area of Aberdeen in the 1930s, one howdie also visited before the birth, again not to give formal antenatal care, but to make sure all was prepared for the birth. Her grand-daughter wrote, ‘On her prenatal visits she instructed the mothers on what she would need regarding equipment at the time of birth and I believe that she was a stickler for having everything ready in advance wherever possible’.<sup>65</sup>

Thus, in Scotland in the early decades of the twentieth century, when most babies were delivered at home by a midwife, antenatal care differed across the country with little midwifery input. Where antenatal care existed, many mothers did not avail themselves of the opportunity unless as in the smaller communities, the midwife attended them at home.

### **Antenatal care in urban areas**

The provision of antenatal care not only differed between urban and rural communities, but also among urban areas. Evidence that provision of antenatal care differed from town to town can be gathered from examination of pupil midwives’ Case Books. From 1928 the CMB required a pupil midwife to present a Case Book at her final examination. This became known as the ‘Blue Book’, and contained a record of twenty women a pupil had cared for in labour, personally delivered and looked after postnatally.<sup>66</sup> Usually the Blue

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<sup>63</sup> LR, 26 [101].

<sup>64</sup> LR, 28 [110].

<sup>65</sup> Written testimony, LR, [3].

<sup>66</sup> CMB Rules, 1928, p 10.



Books recorded the details of ten women delivered in hospital and ten at home. Each mother was allocated four pages in the Blue Book: page one contained an observation chart of the first ten postnatal days; page two gave a brief history of pregnancy; page three gave a brief history of the confinement; and page four was entitled, 'Pupil-midwife's own Review of the Case'. In this page the pupil midwife described the mother's condition immediately prior to labour, details of labour and puerperium.

Included in the history of pregnancy was a brief résumé of the type of care (if any) a mother had received and how often she was seen during her pregnancy. A small survey of six Blue Books has revealed details of the pregnancy histories of 124 women from different places in Scotland from 1939 to 1946.

**Table 6.1 Antenatal care given to mothers in urban areas**

Type of ANC	Aberdeen Mat 1939-40	Glasgow Rob 1947	Edinburgh SMMP 1944	Mother well 1945	Bellshill 1943	Glasgow SGH 1946	Total	%
ANC / municipal	16	17	6	12	8	19	78	63
Admit/ANC	5	1	0	0	0	0	6	5
No ANC	3	1	2	2	0	0	8	6
Own GP / midwife	0	1	1	6	12/ 5	1	21/ 5	17+ 4
Hosp. Clinic	0	0	11	0	0	0	11	9
Total	24	20	20	20	20	20	124	100+ 4

Source: Blue Case Books 1939-1947 belonging to: LR, 80, 16, 108, 2, 90, 93.

Key:

Aberdeen Mat: Aberdeen Maternity Hospital.  
 Glasgow Rob: Glasgow Robroyston Hospital.  
 Edinburgh SMMP: Edinburgh Simpson Memorial Maternity Pavilion.  
 Motherwell: Motherwell Maternity Hospital.  
 Bellshill: County Maternity Hospital, Bellshill. Women lived in surrounding towns and villages.  
 Glasgow SGH: Glasgow Southern General Hospital.

ANC/Municipal:	Municipal antenatal clinic run by the city or town corporation.
Admit/ANC:	Mothers in this category had no antenatal care until they were admitted to the antenatal ward of their maternity hospital for a reason other than labour.
No ANC:	No antenatal care at all.
Own GP/midwife:	Mothers in this category went to their own GP for antenatal care. In a few instances they mentioned that they had seen a midwife there and the extra figures indicate where this has happened.
Hosp-clinic:	Mothers attended the antenatal clinic at the hospital.

The 124 women were chosen for their Blue Books by the pupil midwives and therefore cannot be described as a random sample. Nevertheless, in four out of the six Blue Books the majority of women (sixty-three per cent) attended the municipal antenatal clinic. This meant they received their antenatal care free; they were also probably seen by a public health doctor (who was not necessarily experienced in midwifery/obstetrics) and a midwife, nurse or health visitor employed at the clinic. Thus, when they went into labour, they would very likely be delivered by a midwife or student midwife who did not know their antenatal history. Margaret MacDonald, Green Lady, also implied that she received information about what happened at the clinic from the woman herself rather than from transfer of records.

Antenatal care was [given] at a clinic and it wasn't always the person who was going to deliver the woman who was responsible for the antenatal care... we were responsible for giving her advice and for telling her what she should do but she went to this clinic for any examinations... If it was a hospital emergency [we knew] nothing [about her history]. [If it was a booked case] you knew all about her [through]... what the woman would tell me. How she'd got on at the clinic... There was very little antenatal care... [Most] mothers didn't go to the clinics, definitely.<sup>67</sup>

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<sup>67</sup> LR, 44 [125]. The term 'hospital emergency' was used when a mother wanted a hospital delivery but had not booked and thus frequently did not obtain a hospital bed when she went into labour. These mothers often did not have antenatal care. Mothers who went to the clinics and who were booked to be delivered by choice on the district told the midwife verbally how they had fared at the clinic.

Six per cent of the women whose details are in the Blue Books surveyed, had no antenatal care. This appears quite a low figure, but all of these women came from urban areas where antenatal care was more readily available. Eight out of twenty-four women (thirty-three per cent) in the Aberdeen Blue Book, dated 1939-40, had effectively no antenatal care (five had care after they were admitted to the antenatal ward). This percentage is much higher than the overall six per cent and shows an increase in antenatal care during the seven years covered in the Blue Books.

In only five cases (all Bellshill) the Blue Book specifically mentioned that a midwife was involved in the antenatal care. This occurred at the GP surgery. Each of these mothers had a home birth. There is nothing in the case histories to indicate whether the midwife at the GP surgery was the same midwife in attendance with the pupil midwife at the birth, reinforcing the evidence of lack of continuity of care.

The difference in type of care in different towns/cities is also noticeable. For example, in the Edinburgh Blue Book the pupil midwife was training at the SMMP. Eleven out of the twenty women went to the SMMP antenatally. Therefore they would have seen midwives and doctors who were specialists/or training in obstetrics.

Another type of antenatal care which is evident in the Edinburgh Blue Book was from the Cowgate Dispensary. Of the six who come into the category of ANC/municipal, three went to the Cowgate Dispensary and one of the women who had no antenatal care was a 'Cowgate Dispensary call' when she went into labour. Anne McFadden whose Blue Book gives these details, explained.

So many of the people [in] the poorer areas of Edinburgh couldn't afford to get a doctor so they went to [the Cowgate] Dispensary... The mothers could go to antenatal clinics there... But not so many of them did... The antenatal care was available at the Cowgate Dispensary... I think it's important, not all of

them...made use of it...[Many more of them] could have done, but didn't. Which meant that...in the emergency of the baby's imminent arrival, they had to phone the Cowgate Dispensary which was always manned. And it was all male [medical] students...I don't remember any female...he got the information, he had the address but that was all. And he phoned [for the pupil midwife] and when you went to the house if he was quicker than you he was there, because remember we were walking...and you went down and you examined – you were the one who did the rectal examination. [This is a midwife student] in her second part. And you examined the patient, decided, you know, how far on she was.<sup>68</sup>

Although pupil midwives worked with the Dispensary medical students at home births they did not attend their clinics. '[Midwives didn't work at the Dispensary], not that I know of because you see we in the Simpson had our own ...antenatal clinic.' However, it seemed to be a successful combination. 'We worked hand in hand...It was really a splendid professional relationship'.<sup>69</sup>

As pupil midwives did not use consistent terminology when reporting, it was difficult to estimate from the Blue Books how many visits mothers paid to a clinic. The number ranged from an extreme of twenty visits to one. Pupil midwives also described women's attendance at clinics in terms like 'fairly regular', 'regular', or 'from week thirty-five'. This information demonstrates a lack of a systematic pattern both in number of visits and in the timing of a first visit.

Another Blue Book belonging to Mary Findlay who trained at Dunfermline Maternity Hospital, Fife in 1958-1959, revealed a contrast in care compared with those in the Table above. Although by then the Blue Book contained details of only ten women, the change in type of antenatal care is noticeable. Of five women who were delivered in hospital, all attended the hospital clinic. Of the five who had home births, one attended her own GP, two were attended by their GP and midwife probably at home, one was

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<sup>68</sup> LR, 36 [108]; see also, J Wilkinson, The Cowgate Doctors: The History of the Edinburgh Medical Missionary Society 1841-1991, (Edinburgh: The Edinburgh Medical Missionary Society, 1991).

attended by her midwife at home and the fifth was attended at home but who by is not revealed. The demise of the municipal antenatal clinics started after the implementation of NHS Act in 1948 and this is reflected in Blue Books, in the high percentage attending pre-1948 and no evidence of any municipal clinic in Mary Findlay's Blue Book of 1958-1959. Also, this Blue Book shows a divide between home and hospital care in Dunfermline. Another midwife who trained at Bangour, West Lothian, in the early 1960s said that there, mothers planning a home birth received their antenatal care at home from the midwife.<sup>70</sup> The rise in hospital births in the 1950s corresponds with the rise in attendances at hospital antenatal clinics.<sup>71</sup> However, Ella Clelland training in Glasgow in 1957 showed how many mothers in Glasgow, still having their babies at home, attended hospital clinics.

We saw the mother antenatally but mostly at the hospital at the clinics. She would be seen by the district midwife and student midwife and doctors once a month till thirty two weeks then once a fortnight and then weekly from thirty six weeks. I don't remember much GP input at all.<sup>72</sup>

Sometimes midwives visited antenatally, not to give physical care but for social reasons. This was sometimes to get to know the mother before delivery and to see that she was prepared but also to assess the premises for suitability or otherwise for home birth. Jean Mortimer, pupil midwife at Rottenrow in 1951-1952 wrote, 'our duties outside the hospital consisted of antenatal visits to meet the expectant mum, to assess the

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<sup>69</sup> LR, 36 [108].

<sup>70</sup> Personal communication.

<sup>71</sup> Oakley, *The Captured Womb*, p 144.

<sup>72</sup> LR, 15 [9]; the trend for hospital births in Glasgow was slower than elsewhere because of the shortage of beds. See chapter 7 p 239; Ella Clelland's description of the timing of antenatal visits was to become a traditional pattern.

circumstances in the home to see if they were suitable for the delivery and to encourage attendance at the clinic'.<sup>73</sup>

Mary McCaskill, training as a midwife in 1946-1947 at the Southern General Hospital in Glasgow found the social antenatal visits to be a useful exercise and could give some continuity of care.

During my training in the second part... I always went out with a trained practising midwife... employed by Glasgow Corporation [a Green Lady], and carried out confinements under her supervision... And usually I had the opportunity to get to know the pregnant ladies during their antenatal period a little bit before so that I wasn't going [in] as a stranger... it was quite usual.<sup>74</sup>

Ella Clelland, also assessed the homes and said, '[we] visited them at home to assess the situation and assess their needs and all that kind of thing'.<sup>75</sup> As the demand for hospital births grew and outstripped the number of beds available the next step was early discharge home. Midwives visited, not only to assess their suitability for home birth but also for early discharge.

### **Antenatal care in rural areas**

In rural Scotland antenatal care was inconsistent and depended on where a mother lived, the proximity of a clinic, her motivation and the presence or absence of midwives and GPs. Doddie Davidson was a howdie in rural Aberdeenshire in the 1930s and 1940s and obtained work sometimes by recommendation of the GP and often by word of mouth. She said

Sometimes they knew there wis a baby expectit sometimes they didna. They hid nae nursin care. This wis in the thirties. They hid nae antenatal care. He [the GP]

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<sup>73</sup> J Mortimer, *Tending to Care*, 2<sup>nd</sup> ed., (Bedale: Blaisdon Publishing, 1999), p 104.

<sup>74</sup> LR, 35 [27].

<sup>75</sup> LR, 15 [9].

wid ken if the mother hid been ill or if some of the bairns hid been bad an he'd been up tae the hoose. Bit itherwise, no no, they didna get ony lookin efter.<sup>76</sup>

Another howdie, Annie Kerr, worked in the rural area around Dumfries and as mentioned above she went before the birth to look after the mother and run the household. She also told what she saw as the GP's input into the mother's care: 'I can min Dr Welsh gied me great jobs. He'd be attendin her an watchin her aa the time and he would know when the baby wis due'.<sup>77</sup> Also in the Dumfries area, in the late 1940s, Peggy Grieve working as a midwife in Cresswell Maternity Hospital, Dumfries, described antenatal care in the community but also highlighted the importance given to a hospital clinic visit, and the difficulties getting there, also stressed in the Montgomery report.<sup>78</sup> A mother could be away from home all day just to attend.

Some clinics were at the hospital and I can remember a woman coming... and she said... 'Can I get away by three o'clock because I must get a bus from the White Sands at half past three?' And I said, 'I'll try, yes. Is there not another bus?' 'No,' she said, 'That's the last one... I left home at half past eight this morning.' She came from the Thornhill direction so she had to get a bus to Thornhill, from Thornhill to Dumfries and from the town centre up to Cresswell, and... back. By the time she got home it would be about half past five, sixish... she was away all that length of time.<sup>79</sup>

Similarly, some mothers from Glasgow had to travel seventeen miles out of the city to get to the clinic at Lennox Castle, opened as an Emergency Maternity Hospital during World War II. Anne Bayne did midwifery training there in 1951 and told of problems not just of getting to and from the clinic but how bad news was given.

The patients used to have to travel [by bus] from Glasgow from Dundas Street, and you... had about half a mile up the avenue to come to the clinics... and the consultant saw them out there... A lot of the mothers came out to Lennox Castle... [there were] three consultants at the time that looked after the mothers. It

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<sup>76</sup> LR, 26 [101].

<sup>77</sup> LR, 28 [110].

<sup>78</sup> Montgomery Report, para 22.

<sup>79</sup> LR, 16 [102].

could be hard going. The clinic that sticks in my mind very much was a young lass expecting her first baby... Tweedie Brown... examined her and he said to her, 'Oh well lass,' he said, 'I'm afraid the baby has died. Now you'll just need to go home and wait and when you go into labour, come back in.' And out she went... And I thought this is terrible, this young lass. She would need to get the bus back into Dundas Street and she could have come from the other side of Glasgow. She maybe had to wait and probably her husband wouldn't be at the bus stop waiting for her. She had still to get a bus to go somewhere else... I got her dressed and there was another woman who was expecting baby number three or four and I said to her, 'Are you going back to Glasgow?' and she said, 'Yes I am'. And I said to her, 'Do you see that lass there? Do you think you could take her under your wing. She's had a wee bit of bad news and I don't think it has sunk in and I don't know if her husband is going to be at Dundas Street to meet her.' She said, 'Dinna you worry nurse, I'll look efter her'. So I had to depend on this woman to take her down to the bus and see her home. And then she just had to wait until she went into labour. They didn't induce labour for that at that time and she had her stillborn baby. It was a shame but that was just the norm then and there were high parities, eight, nine, ten was quite usual.<sup>80</sup>

The provision of antenatal care in rural Scotland varied on the area and also on current events. The 1937 Maternity Services (Scotland) Act provided for the development of a more cohesive maternity service in Scotland.<sup>81</sup> Although World War II started before the Act was fully in operation, in the 1940s there was more co-operation between the members of the maternity services team. However, when the NHS started in 1948 with its tripartite system of maternity care and high GP profile, any professional ground midwives may have gained as a result of the 1937 Act, disappeared. The Working Party on Midwives reporting in 1949 commented on GPs' takeover of antenatal care and subsequent diminishing of midwives' status.<sup>82</sup> The ideal of complementary working between midwife and GP and the acknowledgement of the midwife as an expert in all aspects of normal childbearing proved difficult to achieve, especially in the field of antenatal care. Opinions of midwives were often disregarded by GPs. One midwife

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<sup>80</sup> LR, 21 [91].

<sup>81</sup> See Chapter 3, p 94.



working in the Outer Hebrides described such an occasion and how she questioned her own diagnosis.

A young girl came from the mainland to have her baby at her granny's... The first time I saw her, I thought, 'She's got a breech' and notified the doctor. We both went and he said, 'Oh no, that's not a breech. There's the head down there'. Of course I was asking myself, is the doctor right or am I? I antenatalled her (sic) twice over a fortnight and I was still convinced it was a breech. There were no phones and somebody came to my door to call me at about two in the morning... I found her very advanced in labour [with the breech presenting]. There was meconium staining and her uncle was dispatched for the doctor about eight to ten miles away. He had to go quite a bit to the next house and waken the neighbour who had a car. The baby was born and I had tidied up before the doctor arrived.<sup>83</sup>

Anne Bayne practising in Tullibody in the 1950s, while happy with her relationship with most of the GPs with whom she worked, described a time when she and the GP did not agree.

This was her fifth baby. She had had twins before and all along she kept saying to me, 'You know I'm haein twins. It's exactly the same as my last twins.' And I agreed wi her. I said, 'You're having twins'. So I said this to the lady doctor. Oh, nonsense, nonsense, she wasn't having twins. This GP would not agree. I said, 'She needs to go into hospital'. 'Oh no, she doesn't need to go into hospital.' So, time wore on and I still insisted that she should be going into hospital and I wrote it in her notes... Anyhow the doctor never went near her, never went to see her but still would not do anything.<sup>84</sup>

After both babies were born at home and the Flying Squad was at the house to assist in what became an emergency, the consultant obstetrician asked Anne Bayne why the mother was being delivered at home.

I said, 'Dr Rose, it's not my wish. I've been trying since she was four months [pregnant] when I knew it was twins to have her hospitalised. One, because of her age – she was in her early forties by then and two, because I knew it was twins

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<sup>82</sup> Ministry of Health, DHS, Ministry of Labour and National Service, Report of the Working Party on Midwives, (London: HMSO, 1949), Postscript to the Introduction, p viii.

<sup>83</sup> LR, 23 [99].

<sup>84</sup> LR, 21 [91].

and I knew the family history. She had problems with the twins the last time.' So you had this sort of thing to contend with.<sup>85</sup>

Some GPs in rural areas had more input into antenatal care. One mother who had her first baby in 1963 in a small town in the north of Scotland said, 'The only professional I saw for my first pregnancy was my GP. There was no antenatal clinic. I just went to the surgery. I never saw a midwife at all until I went into hospital to have the baby.' However things were different when she decided to have her second baby at home. 'This time the midwife visited me at home the whole time. Once a month, then every two weeks and then every week. But not only that, a few days after the midwife had been, along came the doctor and did exactly the same.'<sup>86</sup> Such duplication of care which has increased over time is not cost-effective, emphasises the 'abnormal side of pregnancy' by the constant medical presence and 'deprives the midwife of an interesting and useful side of their work'<sup>87</sup> while at the same time undermining the midwife's confidence in her ability to do her job properly.

There appeared therefore, to be a lack of cohesion in the provision of antenatal care in rural Scotland. This only gradually began to come together after the reports of the Montgomery and Tennent Committees in 1959 and 1973 recognised the need for change and made recommendations.

### **Changes in antenatal care: integration and new schemes.**

Changes in the provision of antenatal care were apparent from the start of the NHS in 1948 although the varied service to women across Scotland particularly in rural areas

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<sup>85</sup> *Ibid.*

<sup>86</sup> LR, [123], personal experience.

<sup>87</sup> Cumberlege, *Maternity in Great Britain*, p 47.

continued. From the date of its implementation, as far as maternity services in Scotland were concerned, the administration of the NHS was a disappointment.<sup>88</sup> In 1959 the Montgomery Committee's report recommended greater co-ordination of the disparate arms of the maternity services under one person, the GP. 'Co-ordination' became 'integration' demonstrated by the 1973 report of the Tennent Committee together with the re-organisation of the NHS in 1974.<sup>89</sup> The Tennent Report acknowledged that midwives were 'well on the way to integration'. Yet it stated that midwifery services were still divided into community and hospital which would be improved by better co-ordination.<sup>90</sup> Nevertheless, Agnes Morrison in Leith reported some co-operation between hospital and GP in the 1940s.

'They would maybe go to the clinic in the Simpson and then the [doctor there] would say, "Now we'll write to your GP and he will check on your... state of health". It would be monthly then or something. And if he was worried he would send them back. [It was a sort of ] shared care.'

However, on the downside, she also said 'most of ...the mothers [I delivered] I'd never seen ...before. [They had] no antenatal care.'<sup>91</sup>

One example of an early attempt at integration of antenatal care of a kind (although it probably was not called that) was started in the Dumfries area in the 1950s because of the distances women had to travel to go to the hospital clinic. Peggy Grieve explained.

After that, some more obstetric staff came and they started peripheral antenatal clinics and they were in Langholm, Annan, Castle Douglas, Kirkcudbright, Newton Stewart and Stranraer and Kirkcubright.... So the doctors went out to these

<sup>88</sup> See chapter 4, p 135 for further discussion of the NHS.

<sup>89</sup> SHHD, *Maternity Services: Integration of Maternity Work*, the Tennent Report, (Edinburgh: HMSO, 1973); See chapter 5, p 157 for discussion of the re-organisation of the NHS in Scotland and for integration of maternity services.

<sup>90</sup> *Tennent Report*, Chapter 8, 'The Role of the Midwife in an Integrated Maternity Service', pp 29-31.

<sup>91</sup> LR, 31 [35].

clinics but the clinics were run by the domiciliary midwives. Often they were treble-duty staff in those areas. The mothers' records were kept in the hospital.<sup>92</sup>

In a similar way, but in a city setting, peripheral or satellite clinics provided antenatal care for women in Aberdeen from the 1950s, staffed by community midwives and obstetric registrars.<sup>93</sup> Most new schemes which followed involved variations of the integrated service as advocated by the Tennent Report but were also a response to consumer criticisms of the 1970s. Hall *et al* suggest that debates on the maternity services developed rapidly in 1974-75, firstly because of the speed of technological change (and possibly the indiscriminate routine use of new technology). Secondly, social movements evolved. These included the women's movement, protesting about women's alienation from their bodies and male medical domination, the ecology movement towards things natural, and a fast-growing consumer movement desiring more control over bureaucracy and insensitivity. Thirdly, there was the anti-medicalisation lobby, which queried the causal relationship between medical advances and improved health.<sup>94</sup>

An innovative new scheme started in the Sighthill Health Centre, Edinburgh, in 1976 after statistics revealed a possible correlation between poor attendance rates at antenatal clinics and high PMR.<sup>95</sup> A combination of community midwife, GP and/or consultant offered women antenatal care on an individual basis depending on the level of perceived risk. Once the scheme was established, consultants left most of the clinics to the midwives and GPs, thus giving them more time to devote to mothers at higher risk. Midwives, more able to use their initiative, arranged domiciliary visits, made decisions

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<sup>92</sup> LR, 16 [102].

<sup>93</sup> M Hall, S MacIntyre, M Porter, *Antenatal Care Assessed*, (Aberdeen: Aberdeen University Press, 1985), p 8.

<sup>94</sup> *Ibid*, pp 2, 8, 23; SHHD, *Maternity Services: Integration of Maternity Work*, Tennent Report, (Edinburgh: HMSO, 1973).

about hospital admissions, arranged scans, gave total prenatal care if appropriate and worked more as team members. They also found it satisfying to give postnatal care to women they already knew well. GPs felt less sidelined as they took on more responsibility and decision-making. Women received good quality care locally with greater continuity than before. That the scheme appeared to be a success is shown by the improved statistics in the table below. A similar decline in the PMR took place in a corresponding scheme in the Borders.

**Table 6.2. Sighthill Health Centre Antenatal Clinic:  
change in statistics after five years<sup>96</sup>**

	1971-1975	1976-1980
Early attendance at clinic	63%	95%
Default rate	16%	1%
Mean antenatal bed occupancy, days/woman	8.5	4.1
Premature delivery rate	15%	7.8%
Intra-uterine growth retardation rate	15%	6.9%
PMR	27.9/1000 (1975)	8/1000 (1980)

Other innovative schemes started. When Peggy Grieve went to Fife in 1970 as Principal Nursing Officer (Midwifery) she was instrumental in setting up integration of maternity services there. It was probably a job for a diplomat.

Dr Melville who was MOH in Kirkcaldy...approached [me] about integration Would the hospital not take over the midwifery in the burgh of Kirkcaldy? ...There were no [home] confinements...but there was [postnatal] follow up of patients...they granted me money for a full time and a part-time midwife. So that was it started in Kirkcaldy. Then Dr Riddle who was MOH in Fife County came and they were not prepared to give any money for staff so we had to get it through the Hospital Board...So we took over Glenrothes next. Then we...took over the district between Glenrothes and Kirkcaldy. We also did Burntisland, Auchtertool, Puddledub, which was East Fife and then we took over North East Fife...on the

<sup>95</sup> K Boddy, I J T Parboosingh, W C Shepherd, *A Schematic Approach to Prenatal Care*, (Edinburgh: 1976).

<sup>96</sup> C Staines, 'Moving Forward in Antenatal Care: The Sighthill Project, Edinburgh', in *Midwives Chronicle, Supplement*, September 1983, pp 6-9.

first of June... it was snowing that morning. The last place was Leven and that area... As we took over we offered the GPs a midwife to go to their antenatal clinics.<sup>97</sup>

Some GPs were reluctant at first and Peggy Grieve found she had to go slowly.

I remember going to the GPs and saying, 'Now she's coming to your clinic but I don't expect her just to take blood pressures and test urines... She's there as a midwife and... she can examine some of your patients'. 'Well I like to do my own', said one GP. And I said, 'Well, OK, but,' I said, 'she can give advice to the patients on health issues and things like that'.<sup>98</sup>

However, Peggy Grieve had to quote the Rule Book to one GP who finished up happy with the situation..

The biggest fight I had was Auchtermuchty with Hugh Muir and of course he liked to have everything his own way, and it hadn't been his idea, and when I went to see him... I said, 'Dr Muir, you were a member of the Central Midwives Board. You know what the statutory ruling is and,' I said, 'not every patient is being followed up by a midwife here and it must be a practising midwife'. 'Is there a difference between a midwife and a practising midwife?' Anyway, we started it and I met him sometime later. 'That was a great invention.'<sup>99</sup>

There were also the professional feelings to consider, of health visitors who did some postnatal visiting.

You had to watch very carefully with the health visitors, I could see. I had a meeting in Glenrothes with the health visitors when we were taking over and they were there with the guns and I thought if I lose this I'm finished. I hadn't been in post very long, only a year or a year and a half. And they said, 'What's wrong with us doing the visiting?' I said, 'Nothing wrong with you but what it must be, it must be a midwife for at least ten days [postnatally], longer if necessary'. ...Anyway, parted with a cup of tea and a chat.<sup>100</sup>

The system seemed to settle down well.

But it went well... I hand-picked the midwives... I can remember... one midwife coming into the office this day, 'I thought I would just come and tell you Miss Grieve, I was at Cardenden and Dr[ ] said to me, "Would you like to come and

<sup>97</sup> LR, 16 [102].

<sup>98</sup> *Ibid.*

<sup>99</sup> *Ibid.*

<sup>100</sup> LR, 16 [102]; see also chapter 8, p 269 for discussion on health professionals other than certified midwives doing postnatal visits: *CMB Rules*, 1968, p 12.

palpate this patient. I'm not sure what way she's presenting". And she said, 'I just said to him, "It's a breech." And he said, "Oh dear."' So she said, 'I'll tell you what we can do'. She [the mother] was about thirty-four weeks... She said, 'I'll get the obstetricians to get her into the clinic'. Now you see that was the relationship, but she was good... and they all appreciated what the integration was. What annoys me is that other places in Scotland did not push ahead with it the same way as we did.<sup>101</sup>

Peggy Grieve's last comment was echoed by the CMB in their Evidence for Royal Commission on the NHS in 1976. 'The Board deplore[s] the slow progress of integration of the maternity service, which is probably the area *par excellence* where integration could and should occur.' The Board's evidence also emphasised the importance of the role of the midwife.

It is imperative that the midwife should be consulted at all levels of decision making so that her experience and expertise may be available... The Board [is] concerned that in some instances she is not participating fully in health education and thus some pregnant women are being deprived of the counsel and skills of a practising midwife.<sup>102</sup>

Thus the CMB, by this time, stressed the need for the midwife to participate actively in antenatal care of women in all its facets.

Another example of change in antenatal care came from Aberdeen. In the mid-1970s an assessment of the system of antenatal care in Aberdeen, which was similar to others at the time in Britain, was instrumental in providing an alteration in practice and pattern of care. Antenatal care was routine and structured, with little room for individuality and dominated by doctors' decision-making. Where a midwife was involved it was usually as an assistant to the doctor role although occasionally community midwives saw women independently at satellite clinics. Women were disappointed with

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<sup>101</sup> LR, 16 [102].

<sup>102</sup> NAS, CMB 1/10, Evidence for Royal Commission on the National Service, December, 1976.

the care they received and service providers were concerned that antenatal care was not as good as it could be.<sup>103</sup>

Important issues addressed by the new system were ‘who provides care for whom, how often, in what location, recording what measurements and information, and with what consequences?’<sup>104</sup> This resulted in three new main features: women in ‘low-risk’ categories would have less routine care; GPs and midwives would have more input into their care; where there were problems, their diagnosis and management should be improved.<sup>105</sup> In theory, midwives were to take more responsibility for antenatal care. This involved running midwives’ clinics at Aberdeen Maternity Hospital (AMH), peripheral clinics for low risk women, and GP antenatal clinics, performing domiciliary visits and giving home antenatal care to women who would not attend the clinic. In practice the redistribution of care was not as great as had been hoped. Possible reasons for this included small numbers of women in the low risk category now attending the AMH and satellite clinics, possible reluctance of obstetricians to refer women to midwives, nervousness on the part of the midwife, and reluctance of GPs to take on a midwife attachment even though by 1983 many had given verbal agreement to this.<sup>106</sup>

Hall *et al*’s conclusions also highlighted some home truths about maternity care professionals which may have helped them come to terms with further change. They concluded that each professional group involved, to a certain extent believed that it was the best one to offer women information, advice and reassurance. Also, they thought it

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<sup>103</sup> Hall *et al*, Antenatal Care Assessed, Chapter 3, ‘Before the Innovation’, pp 21-36.

<sup>104</sup> *Ibid*, inside dust-jacket, front.

<sup>105</sup> *Ibid*, p 65.

<sup>106</sup> *Ibid*, p 42: Community midwives who were already seeing women on their own at satellite clinics felt less anxious about the new system than did AMH clinic midwives who worried about the increased responsibility and that they might ‘miss something important’ and be blamed for it; *Ibid*, Chapter 4, ‘The Implementation of the Innovation’, pp 37-49



might not be possible to improve the position of any one of the three main providers of antenatal care without detriment to the position of another. Moreover, professionals' and pregnant women's interests did/do not always coincide. Hall *et al* pointed out that each group of professionals while purporting to know 'what is best' might find it difficult to accept that a pregnant woman might not agree.<sup>107</sup>

Despite, or perhaps because of, the conclusions above, change continued in Aberdeen in particular and Scotland in general in the later years of the twentieth century. Antenatal care became more community orientated with greater midwife input and the recommendation that each woman should choose a maternity care co-ordinator, who could be the woman's midwife or GP. This person should be responsible for planning with the woman, her personalised care, tailored to meet her individual needs.<sup>108</sup> Alison Dale, midwife in Aberdeen described what happened in Aberdeen.

Tucker is a new system of care... The instigators were our Dr Hall and ...Dr Janet Tucker... The care... is either community care, or shared care which is hospital and community. If everything is straightforward whether primis or parous patients, they can have their care in the community. That is midwife and GP, or just midwife... with only two visits to the hospital. That is one for a booking scan and one for a detailed anomaly scan at twenty weeks. All the rest of the care will be done in the community. They are allocated a consultant... but nine times out of ten they never need to [see her]. Shared care is any previous medical problem if they are primis or any previous obstetric or medical problem if they are parous... However they only have a first visit to see the consultant or one of the team and then if they are quite well they go back out on to the community and just referred back if there is a problem. I think mothers who are straightforward don't need to be seen at the hospital.

I do a clinic at one of the surgeries at Holburn. The midwife sees all the patients there. The GPs have very little input and even if there were a problem and you ask them, they're not really all that sure so you just quickly ferry them off.<sup>109</sup>

<sup>107</sup> *Ibid*, p 113.

<sup>108</sup> The Scottish Office, CRAG/SCOTMEG Working Group on Maternity Services, *Antenatal Care*, (Edinburgh: HMSO, 1995), p 4.

<sup>109</sup> LR, 29 [94].

Aberdeen's story is an example of how far midwives have come in one hundred years. There were also other areas which demonstrated that midwives could give innovative, integrated antenatal care even while the CMB was complaining that it was happening too slowly. Jan Fenton became a community midwife in Dundee in 1970 and became well known in her area.

So I went on the community and that was the best thing I ever did... I ended up in Whitfield which was an estate built at the back of Dundee. They built a town the size of Forfar [with] 17,000 people. They had one tiny Post Office, little shoppies and the people had six miles to go in the bus to... the middle of town. And they emptied the centre of Dundee and it was pathetic... poor little things. Unmarried girlies, it was just so desperate... nobody liked [Whitfield]. It was a funny area full of cul-de-sacs... I spent... half of my time visiting girls who defaulted from the clinic at Ninewells [Hospital] because... they had so far to go. And they got sick on the bus and they couldn't afford the bus-fare... I thought, this is silly. Why don't we have a clinic in Whitfield. Well, I desperately upset the clinic sister at Ninewells. They had tried it in Fintry and it didn't work... because the consultant who went there was a big gruff man and wouldn't be nice to them. Now these girls are very vulnerable... they didn't need somebody to be rotten to them. They needed somebody to be couthy, to be kind, to welcome them, to show an interest in them. It took me a year – eventually I [became very angry] in the hospital because nobody would listen to me – that this was what was needed... These were the girls... who needed the most care and weren't getting it. So eventually it was passed and I was told I could get on with it. That was it. Now I had never set up a clinic in my life, not a clue... but I knew all the doctors and one... had just become a consultant and he hadn't already got his niche... So I approached him. 'Would you be willing to come to Whitfield?' 'Yes,' he says. So we had a consultant. And we were given six months to establish this clinic and we started off with four patients... all we were allocated... and at the end of the six months we had twenty... We progressed from there because... I said 'well, why don't I book them?' because they were defaulting from booking clinics. So I booked them at Whitfield as well and of course, if they didn't come I would just appear at the house [at] five o'clock in the evening... I would knock on the door and say, 'We missed you at the clinic today. Are you OK?' One day I heard this chap [in the clinic] saying, 'Oh we thought we'd better bring her to the clinic or that wumman wid ha bin at the door again.' But then you see they began to realise that there was somebody who was thinking that it was important and they needed the care.<sup>110</sup>

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<sup>110</sup> LR, 40 [116].

## Conclusion

This chapter has attempted to chart some of the changes which occurred in antenatal care in Scotland during the time of the CMB's existence. It has endeavoured to highlight issues relevant to antenatal care from the point of view of midwifery practice, where appropriate using examples from oral history testimonies. Early in the twentieth century there was little care for pregnant women from either midwives or medical practitioners. Even after the 1915 Midwives (Scotland) Act and the establishment of the CMB, mention of any care a midwife might give to a pregnant woman was sparse. Furthermore, rather than midwives giving antenatal care to women who booked them for delivery, the CMB required midwives booked for delivery to instruct women to attend the LA clinic or GP.

The 1937 Maternity Services (Scotland) Act attempted to co-ordinate maternity services. However any possible encouragement of midwives as the individual responsible for antenatal care was lost with the advent of the NHS and the use of the GP as first contact for pregnant women along with the increasing trend for hospital births and corresponding medicalisation of maternity care. The Montgomery Report (1959), while acknowledging that a midwife under CMB Rules *could* be personally responsible for a woman during pregnancy, labour and the lying-in period made it equally clear that midwives were a part of the service, the co-ordinator of which should be the GP.<sup>111</sup>

Debates on the maternity services which developed in the mid-1970s corresponded with the 1974 re-organisation of the NHS recommending integration in general and the 1973 Tennent Report calling for integration of the maternity services in

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<sup>111</sup> Montgomery Report, paras 77 and 67.

particular. Most new schemes involved integration of maternity services and tried to respond positively to consumer criticisms of the 1970s.<sup>112</sup>

On the negative side, midwives were still not performing to their full capacity. In 1983, just before the CMB ceased to function, the Report of the Scottish Health Service Planning Council, Shared Care in Obstetrics, stated that 'shared responsibility should extend beyond arrangements between doctors'; that midwives' skills were under-used; and that they should have more responsibility including their own lists of low risk women at clinics and at home.<sup>113</sup> This Report therefore offered more to the midwife as a team player although still in a subordinate role.

In the early 1980s midwives themselves began question their subordinate position. Alison Dale remarked, '[Then] someone once said to me [in the early] eighties, that Aberdeen midwives were well known for speaking up and, perhaps not answering back, but for challenging'.<sup>114</sup> Margaret Kitson offered reasons for the increase in midwives' questioning their subordinate role.

I think what happened was that gradually midwives gained in confidence and I think that came about because over time the calibre of midwife became finer and *that* came about because the education of midwives improved. I think really that's it. As the education of midwife teachers improved so the education of midwives themselves improved. Then gradually because they became more confident, because they were more able to stand beside their medical colleagues, medical domination dwindled. And as well as that of course, the generations changed and the generation of obstetricians who had seen midwives as handmaidens... gradually retired and as those people retired and the younger generation came up, there was a more equal partnership between midwives and obstetricians.<sup>115</sup>

<sup>112</sup> Hall et al, Antenatal Care Assessed, pp 2, 8, 23.

<sup>113</sup> Scottish Health Service Planning Council, Shared Care in Obstetrics: A Report by the National Medical Consultative Committee. (Edinburgh: SHHD, 1983), para 1.6.

<sup>114</sup> LR, 29 [94].

<sup>115</sup> LR, 41 [120].

However, even by 1983, the year of the CMB's demise, midwives' talents were still being wasted as they chaperoned and acted as 'clerkess' to doctors, and endured the frustrating experience of watching doctors repeat examinations they had already performed.<sup>116</sup> As mentioned above, this happened frequently. Yet not all midwives felt themselves to be under-used and undermined. Ella Clelland practised in the late 1970s as a community midwife in Callander and reported positively.

I feel the input that we gave alongside the GP was much more then...to be able to go to the mother as another pair of ears and listen and see how she was as a person was worth it... We would visit one week and then we would see her at the GP's clinic maybe a fortnight later... There was much more co-operation then between the midwives and the GPs. They were very much a team then. At the clinics we worked together and both palpated and compared what we found. And the midwife was included in the plans for a woman. We were lucky here I think. We worked very well alongside the GPs. When I started , midwifery was a very normal process and it was meant to be normal until it was proved to be abnormal. Now, it's abnormal until it is proved normal. Maybe I had the best of it – I think I did. I thoroughly enjoyed all that I did.<sup>117</sup>

This extract highlights that a midwife's ability to be an equal, respected partner in a team of professionals depended upon where and in what situation a midwife was working, and with whom. Jan Fenton, innovative midwife in Dundee, found she had to have a co-operative consultant before she could start her antenatal clinic and a previous clinic in Fintry failed because of the consultant's attitude. However, the degree of equality depended on the attitudes not just of doctors, but of the three main providers of maternity care: midwives, GPs and obstetricians. As long as a midwife's practice was dependent on the whims and personality of another professional she was not practising as a respected and equal member of the team. However, gradually midwives realised that their attitude, too, needed to change. Jan Fenton and Ella Clelland succeeded not only

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<sup>116</sup> Shared Care in Obstetrics , paras 8.1-8.5.

<sup>117</sup> LR, 15 [9].

because of the attitudes of the doctors with whom they worked, but also because of their own determination.

## Chapter 7

### Intranatal care

During the period of the CMB's existence between 1916 and 1983, many aspects of midwifery practice changed out of all recognition. One aspect which did not change was the natural process of normal birth. Yet during this time the shift from an estimated 95 per cent home births to 99.5 per cent hospital births, along with increasing medicalisation of childbirth, took the normality out of many births and had a negative impact on midwifery. Ella Clelland, who practised midwifery from the 1950s to the 1980s moved to Callander in 1978, and she commented on the effect of change from home to hospital deliveries.

When I came, the home delivery levels had dropped and midwifery didn't have the same feel. I missed it ...but people were so full of fear of litigation that it made you stand back from it and that took joy away from the things I had enjoyed in the past. I suppose we didn't stop to worry too much – we just got on with it. You did as good a job as you could... I feel that midwifery now is all abnormal until it is proved normal which is not how it is intended to be and which is very sad. I think when I saw the beginning of abnormal practices which is probably too strong a term to use, was when I saw them starting this induction of labour and people knew that they were going to be put into labour. That for me was the beginning of abnormality. And including midwives as a part of it.<sup>1</sup>

This chapter examines some aspects of the practice of midwives in the care of mothers in labour in Scotland between 1916 and 1983. I shall investigate the extent to which midwives were able to fulfil their role as autonomous practitioners as specified in the 1915 Act. To do this I shall look at the input given by GPs to intranatal care, the work of uncertified midwives or howdies and aspects of the change in place of birth over the

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<sup>1</sup> Oral testimony. For details of the oral interviews conducted in relation to this research, see Appendix 4. LR, 15 [ 9].

years. Using examples from oral history testimonies I also look at the ingenuity and versatility midwives themselves put into their practice.

With the change in place of birth, midwives' relationships with mothers also underwent a change. At home, the mother retained a significant identity. Even though she was in labour and requiring help, she remained the host in her own home. When a woman came into hospital she was no longer in control of her environment. Circumstances dictated a weaker, more subservient role for her and her significant identity was diminished. The midwife's identity in hospital was also lessened by the development of hospital policies to which she had to adhere. This meant that some midwives were no longer able to give mothers the complete care, emotional as well as physical, to which many midwives believed mothers were entitled. One midwife said,

I always feel that women when they are pregnant, when they are in labour and just after, need to be mothered themselves in order to help them to mother, even if they have got a mother-figure in their own family. They need the caring that goes along with midwifery. There was no caring. The women were delivered – it was just like a sausage factory.<sup>2</sup>

### **Who delivered the babies?**

Unlike the midwife's role in antenatal care, from 1915, her statutory role as a person allowed to care for a woman throughout normal labour has never been in doubt. The 1915 Midwives (Scotland) Act and the first set of Rules published by the CMB in 1916 specified the demonstration of competence in intranatal care through a required number of deliveries in order for a midwife to be certified.<sup>3</sup> Later that year the CMB, complete with two midwife members, published a full, more detailed set of Rules, including Rules E dealing with midwifery practice and specifically midwives' duties towards women in

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<sup>2</sup> LR, 20 [85].



labour.<sup>4</sup> Nevertheless, although midwives and medical practitioners were (and are) the only people in Scotland permitted legally to deliver a woman of a baby, the role of the midwife in intranatal care, although enshrined in statute, was, in practice, subordinate to medical practitioners. Midwives were not educated in the same way as medical practitioners and within the CMB-approved training institutions, medical practitioners initially supplied the lectures and through the CMB had a large say in what midwives should be taught.

The power of LAs in Scotland over midwives and their practice developed in the early twentieth century. The 1915 Notification of Births (Extension) Act, governed ‘solely by the need for preserving the health of expectant mothers, nursing mothers, and children up to the age of five’, gave LAs wide powers. Although these powers were supposed to be adoptive, not obligatory, the obligation the Government and the Local Government Board for Scotland (LGBS) placed on LAs was considerable.<sup>5</sup> An important part of this was the initiation of ‘Schemes of Maternity Service and Child Welfare’ which the LGBS invited each LA to submit. Thus, the Maternity Services Schemes in Scotland, gave power to LAs and their MOHs to organise maternity care.<sup>6</sup> Also, through the 1915 Midwives (Scotland) Act, LAs were empowered and obliged to supervise midwives closely. The LA took on the role of LSA and decided who would be IOMs (later Supervisors of Midwives).<sup>7</sup> Dr Leslie MacKenzie, Public Health expert and medical

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<sup>3</sup> NAS, CMB 4/2/9, CMB Rules, 17 April, 1916, p 4, paras 2, 3 and 4.

<sup>4</sup> See chapter 2 p 59.

<sup>5</sup> W L MacKenzie, Report on the Physical Welfare of Mothers and Children. Vol.3. Scotland. (Dunfermline: The Carnegie United Kingdom Trust, 1917), Chapter 49, ‘Schemes of Maternity and Child Welfare’, pp 535-561.

<sup>6</sup> Ibid., p 535.

<sup>7</sup> For further discussion of LSA see chapter 2, page 64. and of IOMs see chapter 2, p 69.

member of the LGBS, considered the Midwives Act and the power it gave to the LAs to be central to the success of the Maternity Schemes.

These powers will materially assist the Local Authority in organising a satisfactory maternity service. It may at once be said that the Board [LGBS] will not approve of any scheme, or portion of a scheme, of maternity service unless the midwives employed are qualified for registration under the Midwives (Scotland) Act, 1915.<sup>8</sup>

Under the Maternity Services Schemes, Scottish medical practitioners continued to take a more active part in the care of childbearing women than their English counterparts and supervised (nominally) all home confinements, although they were not necessarily present at the birth.<sup>9</sup> In the 1946 Survey of Maternity in Great Britain, doctors carried out only twenty-six per cent of rural, and eighteen per cent of urban home deliveries in Scotland. The comparable figures for England and Wales were twenty and twelve per cent.<sup>10</sup> It was difficult to gauge the extent of GPs' active participation in midwifery care at home because, 'when a doctor has been in charge of a confinement, the delivery will in all probability be accredited to him even if it has actually been undertaken by a midwife'.<sup>11</sup> This survey made a distinction between the person in charge of the confinement and the person actually delivering the baby and emphasised that although a doctor was in charge of a confinement that did not necessarily mean that he carried out the delivery.<sup>12</sup> Ann Lamb, who practised as a midwife in Scotland for many years from the late 1920s onwards said, 'I delivered most of my babies at home without a doctor. I felt kind of safer with a doctor but I would still deliver the baby. Oh, yes, the doctor was

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<sup>8</sup> Mackenzie, *Mothers and Children*, p 545.

<sup>9</sup> G Cumberlege, *Maternity in Great Britain*, (London: Oxford University Press, 1948), p 28; The word 'supervised' here is not used in the same context as official 'supervision of midwifery' which the IOMs did. Here it means 'in overall control'.

<sup>10</sup> Cumberlege, *Maternity in Great Britain*, p 68; In 1946 48% of babies in Scotland were delivered at home: Cumberlege p 53.

<sup>11</sup> *Ibid*, p 65.

<sup>12</sup> *Ibid*, p 67.

just there to look on'.<sup>13</sup> The 1959 Montgomery Report on maternity services in Scotland said that a doctor's presence at a delivery 'was scarcely a matter that could be made obligatory' and added that doctors were not usually present at a hospital delivery either.<sup>14</sup>

Irvine Loudon has suggested that about half and probably more, of the births in Britain in the nineteenth century were undertaken by midwives.<sup>15</sup> These were women with no statutory registration, who either obtained a form of midwifery qualification from a maternity hospital or learned midwifery practice by accompanying and learning from a woman known for her experience and thus gradually developed a reputation as midwife herself. However, Loudon pointed out that the fifty plus per cent was not consistent throughout the country. In Glasgow in 1870, seventy-five per cent of mothers were delivered by midwives, contrasting with areas of Edinburgh where midwife deliveries were fewer.<sup>16</sup> These inconsistencies were further highlighted in the EOS's vigorous discussion in 1895, 'Should midwives be registered in Scotland?' Dr R Buist, obstetrician from Dundee, and future Chairman of the CMB, said that 'within three hundred yards of his house there were eight or nine midwives in actual practice'. In contrast, at the same meeting, Dr S Maeve, a GP, said that 'in Berwickshire he had not heard of a midwife and...in Strathavon he had no dealings with midwives at all. He had heard of an occasional attendance by a midwife, but never came in contact with them'.<sup>17</sup> Ferguson quoted statistics for Glasgow Cowcaddens collected by Dr A K Chalmers, MOH for Glasgow, for three months of 1906 which break down the numbers of delivering

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<sup>13</sup> LR, 19 [47].

<sup>14</sup> DHS, Scottish Health Services Council, Maternity Services in Scotland, (the Montgomery Report), (Edinburgh: HMSO, 1959), p 18.

<sup>15</sup> I Loudon, Death in Childbirth, (Oxford: Clarendon Press, 1992), p177.

<sup>16</sup> Ibid, p 176.

<sup>17</sup> The Transactions of the Edinburgh Obstetrical Society, Vol 20, Session 1894-95, (Edinburgh: Oliver and Boyd, 1895), pp 169 and 172.

professionals further and show the extent of midwives’ involvement in this area at that time.<sup>18</sup>

**Table 7.1 Number of deliveries per category of professional:**  
**Glasgow Cowcaddens, 1906**

Category	Number	Percentage
Doctors	79	25.5
Maternity Hospital Nurses (sic)	12	3.9
Nurses from other training schools	77	25.0
Handywomen/howdies	126	40.7
Delivered in poorhouses	3	1.0
Not found when visited	12	3.9
Totals	309	100.0

Table 7.1 shows that of the 309 births in the sample, 215, 69.6 per cent were delivered by midwives at some level, fifteen, 4.9 per cent were probably delivered by midwives and it is probable that there would have been some kind of semi-experienced person, for example a neighbour or howdie, present at the seventy-nine deliveries where a doctor delivered the baby. Cowcaddens was considered one of the poorer parts of Glasgow and it was in villages and working-class areas of towns and cities where midwife deliveries predominated, while GPs delivered the babies of the small non-manufacturing towns, suburbs and affluent areas of large towns and cities.<sup>19</sup> This echoes the 1948 Report on Maternity in Great Britain which said that GPs were more likely to deliver the baby if the mother was the wife of a professional and salaried worker and having her first confinement. The figures become correspondingly less, lower down the social scale.<sup>20</sup>

<sup>18</sup> T Ferguson, Scottish Social Welfare: 1864-1914. (Edinburgh: E &S Livingstone, 1958), p 510.  
<sup>19</sup> Loudon, Death in Childbirth, p 176.  
<sup>20</sup> Cumberlege, Maternity in Great Britain, p 66.

### Uncertified midwives – the howdies

Although medical practitioners and certified midwives were the professionals recognised as legal birth attendants, there was another group who had an important part to play in the field of childbirth and it is appropriate to examine their practice at some length. In rural Scotland in the early twentieth century, trained midwives were seldom available and most of the babies were delivered at home by untrained midwives or howdies.<sup>21</sup> That this was a very old tradition is reflected fictionally in John Galt's 'The Howdie'. This howdie obtained her post through the auspices of the local minister's wife and the 'Leddy Dowager' and succeeded the existing howdie when she became ill. According to the story she did not appear to work with doctors but found herself in competition with them.

I cannot tell how it happened that there was little to do in the way of trade all that winter, but it began to grow into a fashion that the genteeler order of ladies went into the towns to have their han'lings amang the doctors. It was soon seen, however, that they had nothing to boast of by that manoeuvre, for their gudemen thought the cost overcame the profit, and thus... whatever the ladies thought of the doctors, their husbands kept the warm side of frugality towards me and other poor women that had nothing to depend upon but the skill of their ten fingers.'<sup>22</sup>

Howdies could call for medical aid if they had problems as noted by MacKenzie:

'There are no trained midwives in the district, [Unst, Shetland, 1917] but there are four very capable women who attend most of the confinements, the doctor being called in when labour seems for some reason unknown to the midwife to be unduly prolonged.'<sup>23</sup>

The procedure of calling for medical aid when a mother's labour went beyond the bounds

<sup>21</sup> Ferguson, *Scottish Social Welfare*, p 510.

<sup>22</sup> J Galt, (1779-1839) 'The Howdie: An Autobiography', in *The Howdie and Other Tales*, (T.N. Foulis, Ltd., Edinburgh, 1923), pp 3-28, reproduced from the original manuscript; the 'Leddy Dowager' was the mother of the Laird.

<sup>23</sup> MacKenzie, *Mothers and Children*, p 484. In this report of circumstances on Unst in Shetland, the GP, Dr Saxby, used the term 'midwife' throughout.

of 'normal' became an important Rule for certified midwives as well and was based on the 1915 Act.<sup>24</sup>

Sometimes GPs appeared to prefer working with howdies to certified midwives, as Chrissie Sandison of Shetland illustrated.

The doctor that I remember [in the 1920s]...was a good doctor and the women liked him but he would never fetch the midwife [certified midwife] until she was required. This was my aunt's second baby. She said he sat down the stairs reading a book and he never went upstairs until he knew that the midwife had gone to the lavatory. This was a good bit from the house. It was a wee house across a burn, there was no bucket just a seat across a burn and I don't know about toilet roll – likely it was a bit of newspaper and no buckets to empty. Well anyway when she had to go, he went up to inspect [how the mother was progressing] and then when she came back he would go downstairs again. When she had her next baby, that would be in 1929, she employed another woman, one who had had a big family but who wasn't a certified midwife. Then the doctor was quite happy. He didn't like working with the trained midwife...he maybe thought she knew as much as he did. I think he had a bit of a psychological blockage.<sup>25</sup>

Chrissie Sandison also saw a difference between a howdie and a neighbour. 'I knew another woman who was not happy with the midwife she had for her first, and ever after that she had – not a howdie – just a neighbour. You see they didn't do much – nature did it. A lot of midwifery is just waiting.'<sup>26</sup>

Howdies worked in some parts of rural Scotland until the 1940s and 1950s and especially in the early 1900s were an accepted part of the country scene. Ann Lamb, herself a midwife, was born in Banffshire and delivered by the howdie, Meg Gordon. 'She would have been called the Howdy (sic), the midwife for the district, and she liked a dram...I was brought into the world on 25<sup>th</sup> February 1902.'<sup>27</sup> Ann Lamb also made clear

<sup>24</sup> 1915 Midwives (Scotland) Act, [5 & 6 Geo 5 Ch 91] 22, 1.

<sup>25</sup> LR, 6 [61].

<sup>26</sup> *Ibid.*

<sup>27</sup> A Lamb, *Memories*, Handwritten and tape-recorded, (Northern College, Aberdeen, 1994-1995 Unpublished), p 17. Now published as: A Lamb, 'Life at Larryvarry', in: A Roberts, *Tales of the Braes of Glenlivet*, (Edinburgh: Birlinn Limited, 1999), pp 118-129.

the perceived importance of the GP in midwifery at the time, ‘and there was six feet of snow and the doctor never saw me for six weeks because the roads were all blocked’.<sup>28</sup>

Local GPs, especially in rural areas, could be influential in obtaining positions for howdies. One in particular, Doddie Davidson, had never seen a baby born before she faced her first delivery in Aberdeenshire in the early 1940s. She was eighteen years old, the woman was in labour and her husband was away to fetch the doctor in the snow with the added complication of blocked roads. She recalled,

Meantime Babby wis gettin on wi’t an I thocht, ‘Oh I better get tools an things ready’. I kent foo tae dae at. So I got the tools an bilin watter an a thing for the doctor comin. But it went on fur a couple o oors, maybe langer than at – and then I could see the baby’s heid comin and so here’s the baby, ‘Oh there’s naebiddy here bit me.’ Naebiddy ti help, there wisna neighbours ye see. So I thocht, ‘Fit’ll I dae?’ So I said, ‘Oh it winna be lang noo Babby’. But the heid jist didna come ony further. I thocht, ‘Oh at bairn disna look richt ti me. I na ken fit ti dae.’ An I could see there wis twa cords on its neck. The heid wis oot, an the baby jist didna look richt. It wis growin bluer ... So I pushed the heidie back a wee bittie and I got one finger in below the cord and I got it ower – the second bit o the cord wis easy, it wis the first ye see, An eventually, the baby wis born, nae doctor, nae hubby, naebiddy. I had ti wrap it – bit at the same time the baby wis motionless an blue. An I thocht, ‘Oh well, the baby’s deid’. But I wrappit it up wi a tool an it gaed a kin a half cough and then anither een and then sort of spluttered a bittie and I thocht, ‘Well it’s still here.’ An then aa at aince it gaed a yell and I thocht, ‘Oh God, I wis nivver so pleased to hear a bairn.’<sup>29</sup>

When the doctor finally appeared Doddie was scared that what she had done might have been wrong.

But hooivver, it wis a while efter at, the doctor an her hubby came back an he looked at the baby an, he said, ‘Fit, is this been corded, is it?’ Ye ken, the marks wis still on the neck. An I said, ‘Aye,’ an I telt him. I wis fair shakkin ye ken wi fit I did. Ye ken pushed the baby back a bit and put ma finger in. So he commended me. He said, ‘Oh, at wis jist great.’ He says, ‘Oh I could dae wi you on the [district]’. I wis really worried aboot it, really worried, but no that wis jist it. An I wis wi him a few times efter at.<sup>30</sup>

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<sup>28</sup> Lamb, *Memories*, p 17.

<sup>29</sup> LR, 26 [101].

<sup>30</sup> *Ibid.*

This gives some indication of the deference ‘ordinary’ people accorded medical practitioners. It also demonstrates the GP’s ability to obtain work for howdies and how they worked together. Annie Kerr, another howdie, made similar comments. ‘Dr Welsh knew I likit these kind of jobs away oot of the road of everybody and no other body would go near them... I can min Dr Welsh gied me great jobs’.<sup>31</sup>

However, GPs not only obtained work for the howdies and recommended them to women, they needed them to be there. Ann Lamb indicated this when describing her mother in rural Banffshire. She said, ‘She was a bit of a midwife as well and the Doctor always told them “fetch Mrs. Lamb until I come”’. He had to come all the way from Tomintoul or Achbreck and when Willie was born she didn’t see him there for weeks as there was a storm.’<sup>32</sup>

Howdies were evident in Scotland until at least the 1950s. Some appeared to be very organised and worked closely with the local GP as Johann Robertson did in 1930s Aberdeen. Her grand-daughter wrote,

I was delivered [in 1934] by my grandmother – by Johann Robertson who was the uncertificated midwife for the King Street and surrounding streets. She was employed by a Dr. Coutts who I believe was specialising in confinements and child care. He ran the main surgery in King Street and she was called out at all hours to confinements in houses. She had her own special bag... When a birth happened unexpectedly, Dr. Coutts would collect her in his little car but otherwise she had to walk to all the other call-outs. She liked to be summoned in the first stages of labour to avoid complications where possible and lived and worked by the idea that ‘To be forewarned was to be forearmed’.<sup>33</sup>

However, Anne McFadden was more doubtful about the practices of howdies. In 1951 she moved from the SMMP to a post as district nurse/midwife in Lochgelly, Fife where she came across howdies for the first time. She explained the situation.

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<sup>31</sup> LR, 28 [110].

<sup>32</sup> Lamb, *Memories*, p 9.



At that time there were at least five or six 'domiciliary midwives', but they really...were only...howdies...Coming straight from Simpson where everything was, you know...ahead of its time...I found it extremely difficult because I didn't get a lot of midwifery because these other people were depending on it for a livelihood...of course the people in Lochgelly knew them. They were Lochgelly bodies, so [the mothers booked these howdies]... and the doctor might or might not be involved...they...were known to the doctor. Now...they would only be assisting the doctor, you know, fetching and carrying... So therefore the doctor would be very aware of the capabilities of certain women. Also, their integrity would be important...she was really a handy woman...with little or no training.<sup>34</sup>

Another midwife described a similar situation where the howdie made a habit of getting the delivery instead of the midwife.

In that that area I was in, in Central Scotland [in the 1940s], there was [a howdie]. ...she was very loath to give up. You see she was in an area of town, you know a country area and she was kind and she was the one who would deliver the babies and I think some of [the certified midwives] had battles with her. I think she would say [to the mother], 'Oh you've time enough to send for the midwife,' and then she would be able to get the baby.<sup>35</sup>

Anne McFadden also indicated that the howdie learned from the doctor with whom she worked. 'The doctor might...take her with him, if he needed somebody. Therefore she would get a bit of experience.' But then mothers sometimes just had the howdie. 'They [the mothers] might be lucky if they had the doctor and you just had to hope that the midwife [howdie]...knew enough to know when to get the doctor.'<sup>36</sup> She also voiced concern that the howdies took on mothers who she felt should have gone to hospital to have their babies.

I had been brought up in the Simpson where...everything was done, you know according to the book. And we were taught that ...if somebody had [previously] had a prolonged labour or had to be taken in to have their placenta removed, if she'd had a whole lot of children, you know we were taught you should never accept them on the district...They should be hospitalised. Well you see many of them were like that ... to have eight and nine children wasn't unusual at one time

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<sup>33</sup> Written communication, LR, [3].

<sup>34</sup> LR, 36 [108]; the use of the term 'domiciliary midwife' here means uncertificated midwife.

<sup>35</sup> LR, 23 [99].

<sup>36</sup> LR, 36 [108].

and if you had that nurse (sic) for your first baby and everything was all right, you would go on and have another and so... [this howdie] would have delivered eight and nine of the same family... not always with the doctor. Only if... she was clever enough to spot that there was a problem. I wouldn't have wanted the responsibility of having them... I would just [have] said, 'No, no, no, I think you'd be safer to go into the hospital'. And furthermore... home conditions were sometimes certainly not suitable for home confinement.<sup>37</sup>

However, despite her doubts, she acknowledged that in the early 1950s when there were not enough hospital maternity beds to meet the demand, the howdies came in useful. 'So [if] you were forced to be at home [as] you might if there was a lot of people due, then there wouldn't be enough [hospital beds] so they would need all these "domiciliary midwives" '.<sup>38</sup> The situation in Lochgelly was rectified in the mid-1950s with the intervention of the depute Medical Officer of Health.

Now, Dr Grant was a real pioneer of change when she came... She was depute Medical Officer of Health but with responsibility for maternity and child health in the area and she got ...the only ones that were left by that time to go to Forth Park and that was when they took their training. They'd been doing the work but they got the theory then... I suppose they were still young enough... They'd done sterling work and it would have been a shame just to discard them. She gave them the opportunity of going.<sup>39</sup>

However the presence of howdies at many births seemed to be accepted at least until the 1950s. Anne McFadden said, 'I came here in '51 and they were beginning to fade out then. In the country areas... they would use them much more... where maternity facilities would be at a distance'.<sup>40</sup> This was despite previous legislation and the activities of the GMC to stop GPs 'covering' howdies.<sup>41</sup> Some possible reasons emerge for this. Firstly Anne McFadden's comment on 'needing all these "domiciliary midwives" ' [howdies] raises a question about the staffing levels of midwives in Scotland. During and after

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<sup>37</sup> Ibid.

<sup>38</sup> Ibid.

<sup>39</sup> Ibid.

<sup>40</sup> Ibid.

World War II there was a rising birth rate and a shortage of certified midwives which could have led LAs to turn a blind eye to the activities of the howdie.<sup>42</sup> Secondly, Chrissie Sandison commented that doctors preferred to work with howdies rather than certified midwives. It is possible that this liaison went on far later than has been officially acknowledged. In addition, as Chrissie Sandison indicated above, mothers possibly felt more comfortable with someone they knew well.

### **The change in place of birth**

The shift from home to hospital as the place where most women give birth was one of the major changes in maternity care in the twentieth century. In Scotland, before the beginning of the twentieth century, nearly all mothers gave birth at home. The movement from home to hospital began slowly in the early decades of the twentieth century and reached a peak in 1981 when 99.5 per cent of babies in Scotland were born in hospital.<sup>43</sup>

Reasons for the change particularly involved the growing medicalisation of childbirth through the twentieth century.<sup>44</sup> An important issue was that of pain relief in labour, unknown to most early twentieth century women. Chloroform, first used as an anaesthetic in obstetrics by Sir James Y Simpson in Edinburgh in 1847, and still used in Scotland in the first half of the twentieth century along with ‘twilight sleep’ (morphine and scopolomine) had to be administered by, or under the supervision of, a medical practitioner.<sup>45</sup> Thus, most women receiving these drugs were those who could afford to

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<sup>41</sup> Discussed in chapter 2 p 71.

<sup>42</sup> There is further oral evidence, LR, 35 [27], that Glasgow Corporation used howdies (again called ‘domiciliary midwives’), for postnatal visiting in Glasgow: ‘there were still a few of them on the go’.

<sup>43</sup> GRO Scotland; see Appendix 5: The changing place of birth in Scotland 1900-2000: % of births at home.

<sup>44</sup> See Introduction, p 14 for a definition of medicalisation of childbirth.

<sup>45</sup> D Moir, *Pain Relief in Labour*, 5<sup>th</sup> Edition, (Edinburgh: Churchill Livingstone, 1986), p 1; *Ibid*, p 5. Twilight sleep was first used in Germany in 1902.

pay a doctor as well as a midwife. Constant observation of a mother receiving these drugs was necessary and as in the 1920s private maternity homes and maternity beds in ordinary nursing homes also came into vogue, it was much easier to admit her to one of those if she requested analgesic drugs.<sup>46</sup> Soon, the development of maternity homes increased to the extent that some mothers who could pay, began to go there for their confinement whether they felt they required analgesia or not.<sup>47</sup> In addition, conditions in hospitals improved, with greater attention to design in order to reduce the incidence of cross-infection.<sup>48</sup> Thus their reputation improved, and more women were prepared to go to them. Advances in medicine, instrumental in reducing maternal mortality in the 1930s and 1940s added to the increase in hospitalisation. These included the use of the first antibiotics for puerperal sepsis, particularly Prontosil.<sup>49</sup> There was also the development of blood transfusions, better education of doctors and midwives which led to greater awareness of problems and thus admission to hospital when necessary.

The issue of maternal mortality and the care given to mothers by midwives and doctors was highlighted in the 1935 Douglas and McKinley Report.<sup>50</sup> As the Report emphasised the normality of most births, it was not directly instrumental in increasing hospitalisation for childbirth. Nevertheless, its conclusion reflected the need for

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<sup>46</sup> See chapter 4, p 130 for further discussion of the midwife's role in administration of inhalational analgesia and CMB Rules.

<sup>47</sup> Registration and Inspection of Maternity Homes was made statutory in the 1927 Midwives and Maternity Homes (Scotland) Act, [17 & 18 Geo 5 Ch 17], Part II, pp 5-9; see also chapter 3, p 87.

<sup>48</sup> E F Murray, 'Some Observations on Puerperal Sepsis with Special Reference to its Occurrence in Maternity Hospitals', Transactions of Edinburgh Obstetrical Society, Session LXXXIX, in Edinburgh Medical Journal, New Series, Vol. XXXVII, No. 10, October 1930, p 149. Discussion following this paper; R W Johnstone, 'The Simpson Memorial Maternity Pavilion, Royal Infirmary, Edinburgh', (Manchester: Sherratt and Hughes 1939), reprinted from the Journal of Obstetrics and Gynaecology of the British Empire, Vol. 46, No. 6, pp 1020-1028.

<sup>49</sup> Loudon, Death in Childbirth, pp 258-261.

<sup>50</sup> Discussed in chapter 3, p 88.

improvement in the maternity services in Scotland from both midwives and doctors.<sup>51</sup>

The statutes of the 1937 Maternity Services (Scotland) Act echoed many of the Douglas and McKinley Report's recommendations, in particular the requirement of LAs in Scotland to provide at home the services of midwives along with those of GPs, specialist obstetricians and anaesthetists where necessary.

In 1939, before these arrangements were fully in place, World War II started, bringing with it an acceleration of the trend towards hospital for birth. The most basic reason was lack of help in the house. Many women replaced men away on action, in factories, on the land and in other jobs which were usually male preserves. This meant less help in the home for newly delivered mothers and a consequent greater demand for hospital births. In addition, and probably with longer term effects, there was a distinct change in maternity services from the beginning of the war. Pregnant women, evacuated to reception areas from places likely to become targets for enemy action, were provided with emergency maternity hospitals, often adapted from suitable country houses.

Although 'a drift back home set in almost immediately the scheme was launched', many mothers found that they enjoyed the break from home responsibilities and the trend for hospital in some areas developed rapidly. 'In Glasgow, the Department of Health for Scotland commandeered Lennox Castle (125 beds) in 1943 as an emergency maternity home. When the MOH asked the mothers how they liked it, they said it was a grand idea because they could get a holiday at the same time'.<sup>52</sup> According to Ann Oakley, in the

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<sup>51</sup> DHS, Scientific Advisory Committee: Clinical Sub-Committee, Maternal Morbidity and Mortality in Scotland, (Edinburgh: HMSO, 1935), p 27.

<sup>52</sup> H P Tait, 'Maternity and Child Welfare', in G McLachlan, Ed., Improving the Common Weal: Aspects of Scottish Health Services, 1900-1984, (Edinburgh: Edinburgh University Press, 1987), p 417; A MacGregor, Public Health in Glasgow, 1905-1946, (Edinburgh and London: E. & S. Livingstone Ltd., 1967), quoted in A Oakley, The Captured Womb, (Oxford: Basil Blackwell Publisher Ltd., 1984), p 118

early months of the War, the proportion of institutional births in Glasgow rose by twenty per cent and the change in maternity services during the war was a contributory factor in the sharp post-war upturn in the institutional delivery rate.<sup>53</sup> While booking a hospital bed was strictly controlled into obstetric, medical and social categories because maternity beds were in short supply, by 1948 there were almost 3000 maternity beds in Scotland, a rise of around 2000 since 1934.<sup>54</sup> Most of these came as a result of the war-time maternity policy.<sup>55</sup> According to the Montgomery Report, the plan for maternity hospital and specialist services which the Regional Hospital Boards inherited and developed under the National Health Service, came from the existing maternity services, together with the additions provided during the war.<sup>56</sup> Thus the implementation of the NHS Acts in 1948 and the resulting changes reinforced an earlier wartime trend towards hospital births.<sup>57</sup>

By 1959, when the Montgomery Committee reported, the home birth rate was dropping sharply. In 1957 it was twenty-nine per cent, a drop of fifteen per cent since the start of the NHS in 1948.<sup>58</sup> Evidence to the Report suggested other reasons for the trend away from home births. These included women's demands for hospital confinement because of media suggestions that it was safer, women following fashion, and also women asking for a 'definite booking' as they feared being discharged too quickly if they were admitted in an emergency. However the Queen's Institute of District Nursing,

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<sup>53</sup> Oakley, *The Captured Womb*, p 118.

<sup>54</sup> J Towler and J Bramall, *Midwives in History and Society*, (London: Croom Helm. 1986), p 229.

<sup>55</sup> J Sturrock, 'Edinburgh Royal Maternity and Simpson Memorial Hospital', A Sir James Y. Simpson Memorial Lecture delivered on 11 July 1979, reprinted from the *Journal of the Royal College of Surgeons of Edinburgh*, Vol. 25, May 1980, p 184.

<sup>56</sup> *Montgomery Report*, p 7.

<sup>57</sup> See discussion on the NHS in Chapter 4, p 135.

<sup>58</sup> Figures taken from Statistical Information in the *Montgomery Report*, 1959, Appendix III, p 56.

which included many practising midwives appeared to sum up the evidence of all the other contributing bodies when it explained that the trend was

due to excessive propaganda from hospital specialists stressing greater safety, lack of suitable housing in certain areas, insufficiently developed or insufficiently flexible home help services, economy to the mother...in spite of the increase in the home confinement grant, and encouragement by GPs [to have a hospital birth], sometimes irrespective of medical, obstetric or social need.<sup>59</sup>

The Montgomery Report of 1959 acknowledged that because of insufficient hospital accommodation at the time for women who requested hospital births a form of selection would have to be used. It also even suggested reducing the cost of home helps for maternity cases to try and ‘encourage a new trend towards domiciliary confinement’.<sup>60</sup> Yet to counter this, further medicalisation in the 1950s and 1960s resulted in much more detailed selection criteria for conditions requiring care in hospital.<sup>61</sup> This included an assessment of ‘risk factors’ which doctors and midwives used to advise women and was associated with an increase in antenatal care and testing such as ultrasonic scanning of the fetus *in utero*.<sup>62</sup> In the 1970s and 1980s medicalisation and the use of technology developed further, for example, induction and augmentation of labour, the growing trend for epidural anaesthesia, the rise in instrumental vaginal deliveries and Caesarean section rates. Selection shifted from selection for hospital delivery, to selection for home births.<sup>63</sup>

In 1967, the Central Health Services Council set up the Standing Maternity and Midwifery Advisory Committee in an attempt to consider the future of the domiciliary

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<sup>59</sup> Montgomery Report, pp 14-16.

<sup>60</sup> Ibid, p 39-40.

<sup>61</sup> SHHD, Provision of Maternity Services in Scotland: A Policy Review, (Edinburgh: Her Majesty's Stationery Office, 1993).

<sup>62</sup> Selection criteria have also been used in antenatal care. See chapter 6, p 216.

<sup>63</sup> S Kitzinger, Birth at Home, (Oxford: Oxford University Press, 1979), p 47. Kitzinger noted that a contrasting form of selection happened in the Netherlands where ‘women, instead of being ‘selected’ for home birth, as in Britain, are selected for hospital birth.

midwifery service and the question of bed needs for maternity patients.<sup>64</sup> Obstetricians were influential in the direction of this Committee's Report, published in 1970 and known after the name of its chairman, as the Peel Report. It was widely quoted although it was not officially an expression of Government policy. For the first time a major Report advocated 100% hospital delivery on the grounds of safety, even though recent commentators have argued that there was no supporting evidence for this.<sup>65</sup> As already mentioned in chapter five, the Peel Report did not apply to Scotland. Nevertheless, the SHHD's 1973 Maternity Services: Integration of Maternity Work (the Tennent Report), agreed with the Peel Report's main conclusions and recommendations.<sup>66</sup> Although the Tennent Report did not use the term '100% hospital confinement', it was implicit in the text.<sup>67</sup> The hospital birth rate, which stood at 98.5% in 1973, was set to rise even further.<sup>68</sup> Thus in the space of fourteen years the trend for hospital births, already escalating as a result of events in World War II, the NHS and women's demands, was accelerated by the recommendation for one hundred per cent hospital deliveries.

The change in place of birth also affected the intranatal practice and morale of domiciliary midwives. In the years after World War II and the beginning of the NHS when the number of hospital deliveries was rising, midwives on the district became anxious about what would become of them.

Towards the end of that five years [1952] - the home deliveries had just sort of imperceptibly started to decline ... older midwives ... probably in their fifties were beginning to talk about - they didn't have so many bookings and they were

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<sup>64</sup> R Campbell and A Macfarlane, 'Recent Debate on the Place of Birth', in J Garcia, R Kilpatrick and M Richards, The Politics of Maternity Care (Oxford: Clarendon Press, 1990), p 217.

<sup>65</sup> Ibid., p 218.

<sup>66</sup> SHHD Maternity Services: Integration of Maternity Work, Tennent Report, (Edinburgh: HMSO, 1973), p 2.

<sup>67</sup> Tennent Report, p 13.

<sup>68</sup> GRO, Scotland.



wondering ... what was the future and what would they be used for...would they be maybe diversified into some other duties?'<sup>69</sup>

Furthermore, as the number of home births declined, so did the job-satisfaction of district midwives. Experienced district midwives expressed frustration at what they saw as a lack of domiciliary midwifery. Their remit had moved from giving full intranatal and postnatal care to some antenatal visits and postnatal visits to women who had been confined in hospital. There was also concern, that the lack of intranatal practice would result in a loss of skills for both district midwives and GPs and would lead to difficulties in arranging for intra-partum training for pupil midwives.<sup>70</sup> The CMB Minutes highlighted this problem many times. As the number of hospital births rose, very few student midwives delivered a baby at home, although much depended upon the area and the number of maternity beds there. For example, one district midwife in Govan described delivering a large number of babies.

I was appointed as a district midwifery sister from 1957-1964. Govan was densely populated at that time and the birth rate extremely high. Because of the shortage of beds in the maternity unit of the Southern General Hospital home confinements were essential and during my seven years in the community, I delivered 1,322 babies.<sup>71</sup>

Any student midwives working with that midwife would have had no problem obtaining deliveries and this situation in Glasgow continued for some years. Ella Clelland training at Rottenrow in 1957 said, 'I think we had to deliver ten in the hospital in the beginning and twenty out. We never had any difficulty getting cases – there were always plenty cases'.<sup>72</sup> Twelve years later, Maureen Hamilton, student midwife in Glasgow in 1969 said, 'We had quite a few home deliveries and no problem getting them. I think probably

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<sup>69</sup> LR, 35 [27].

<sup>70</sup> Montgomery Report, 1959, p 20.

<sup>71</sup> Written communication, LR, [34].

after that – that was 1969 I finished...they were beginning to go down a bit in numbers. But certainly none of our crowd had any problem'.<sup>73</sup> Yet Alison Dale, who also trained in 1969, but in Aberdeen, said, 'Only one girl in our set...saw a home delivery and there were very few by the time that we were training'.<sup>74</sup> Thus, sooner or later, home births were phased out as a compulsory part of the midwifery training syllabus and as Wilma Coleman, midwife, said, 'Now, generally speaking, all community midwives have a hospital background. But...once the [number of] home confinements went down and women came into hospital, the community midwives very quickly lost their intrapartum skills'.<sup>75</sup> One solution to this issue was a suggestion in the Montgomery Report that 'domiciliary midwifery might become a hospital responsibility, which would allow some interchange of midwives between domiciliary and hospital services'.<sup>76</sup> This early suggestion on integration of the maternity services was to come to fruition in future years.<sup>77</sup>

Another suggestion in an effort to provide more continuity of care for mothers and at the same time help community midwives maintain their skills, was what became known as the DOMINO scheme.<sup>78</sup> The first reported use of this scheme was in West Middlesex in 1971, although ideas for similar schemes were mooted in the early 1960s. Mothers having a DOMINO delivery were looked after antenatally by their community midwife, escorted into hospital in labour by the community midwife on call, who then delivered the baby and looked after the mother and baby for a few hours afterwards

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<sup>72</sup> LR, 15 [9].

<sup>73</sup> LR, 30 [112].

<sup>74</sup> LR, 29 [94].

<sup>75</sup> LR, 12 [74].

<sup>76</sup> Montgomery Report, 1959, p 20.

<sup>77</sup> See discussion on integration in chapter 5, 157.

<sup>78</sup> DOMINO stands for DOMiciliary IN and OUT.

before escorting them home. Postnatal care continued as usual. DOMINO deliveries had the added bonus for the midwives that they could give intranatal care as well.<sup>79</sup> Jan Fenton had many DOMINO deliveries over the years. She said,

We started the DOMINOS in the 1970s. A lot of the girls...were frightened of hospitals. [There was] a little lass...and she wanted the baby at home and of course those were the days when...it was very much frowned on. She was determined. She discovered that she was having twins...But we went into hospital with her...Dr Smith [the consultant] got out of his bed at two o'clock in the morning and sat beside the bed so that there was no interference from the staff. You see this is the rapport...that we had. I delivered the twins...it was marvellous. And then eventually I was delivering babies from all over the town...They'd obviously had a bad experience the first time. I got up in the middle of the night, went in, delivered a baby and came home. But you see I was using my expertise in the hospital and this was one way of keeping it up...These were all DOMINOS...It was brilliant...Eventually I think I did about twenty-four in a year. Now that was two a month and it's quite a lot when you consider getting up during the night or at weekends. And I've even done it on my day off because they were – if they were frightened they were frightened.<sup>80</sup>

### **Challenges of home births: pests and poverty**

Discussions on home and hospital births tend to centre on safety and its statistics. But most midwives I interviewed spoke of other challenges such as dealing with body-vermin and poverty, as well as their reaction to acute situations.

One constant feature, significant by the number of midwives who spoke about it, was the presence in many homes of bugs, fleas and lice. They had different ways of handling these. Anne Bayne working in the early 1950s said,

We lived our lives with fleas. In fact we got a chemist to mix DDT with our talcum powder to try and control fleas because I used to just come up in great welts with fleas. Montrose Street itself where we sat and waited to be called out

<sup>79</sup> T Murphy-Black, 'Systems of midwifery care in use in Scotland', in *Midwifery*, 8, 1992, pp 115; R Campbell and A Macfarlane, *Where to be born? The debate and the evidence*, 2<sup>nd</sup> ed., (National Perinatal Epidemiology Unit: Oxford, 1994), p 93.

<sup>80</sup> LR, 40 [116].

for deliveries – it was just hotching with fleas. So we dusted everything we could with this DDT-talcum powder to try and keep the fleas at bay.<sup>81</sup>

Mollie Muir, pupil midwife at the ‘old Simpson’ in 1934, like other pupil midwives had to take medical students to homebirths as part of their training. On one occasion she remembered coping when a bug landed on her student. But normally she took unwanted livestock as a matter of course. She recalled,

The night that I was at this thirteenth baby, the student who was with me, ooh he was spotless. and he had on a lovely forget-me-not blue shirt, just stiff with being well-washed and well-ironed, and suddenly a great fat bug jumped on to his sleeve. I took it with my fingers and threw it down and stood on it. But apart from that of course we had a lot of lice and fleas. We didn’t have to de-louse ourselves because you see we wore caps and the whole idea of the cap was to keep the lice from your hair.<sup>82</sup>

Bugs, fleas and lice were so commonplace that it was standard practice for pupil midwives to be taught what to do with their coats when they were in someone’s house.

Betty Smith said,

Another thing we were taught [in the 1940s]. I don’t know if it applies now, never to put our coats over a bed or a soft chair. We always had to hang our coats on a hard chair because of bugs. Bed-bugs. I mean that didn’t apply to every house; but that was what you were taught.<sup>83</sup>

But Margaret Foggie, in 1934 found another use for newspapers.

I remember seeing bugs on the wall, various things on the wall... I didn’t know quite where to hang my coat in the houses. I would wrap it up in some of the newspaper – we went bulging with newspapers. It was used for everything.<sup>84</sup>

If all precautions failed Agnes Morrison described what she had to do in 1946 once she returned home.

If I’d been down there [Leith Walk] I can remember what I really had to do... Take my apron off, go into the bathroom, stand and strip [and have] a piece

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<sup>81</sup> LR, 21 [91].

<sup>82</sup> LR, 13 [46].

<sup>83</sup> LR, 27 [93].

<sup>84</sup> LR, 22 [50].

of soap in my hand to catch the fleas...to get them to go against the white and you know, getting them...Fleas seemed to like me. I'd be covered in fleas at night...Those houses must be riddled.<sup>85</sup>

The poverty epitomised by these quotations was echoed over and over again by midwives who told their stories. The problem of lack of equipment arose frequently and the solutions demonstrated midwives' ingenuity and versatility. Ann Lamb training as a midwife in Edinburgh in 1927 managed to take a positive attitude.

They were very poor, and by poor, I mean poor. There was only one sheet to deliver the mother on, so a firm was very good and gave us paper, white wallpaper, and we made a sheet of that. We never had any sepsis, don't forget, and we had nothing much to work on, but I never remember a case of sepsis or anything wrong with the mother or baby. They were very happy but oh, they had nothing.<sup>86</sup>

Many midwives used newspapers to put under the mother. Margaret Foggie from South Africa working in Glasgow in 1934 told what she did.

We delivered the baby ...straight on to newspapers. The other children and the father would all have had to have been turfed out. I did hear from somebody later that very often the father was still in the bed. He was working during the day so he had to have his sleep and you would have to get him out at the last moment. I never quite had to do that. I always managed that earlier to give me a clear run. The poor mothers they really didn't - after they had had nine or ten children - they didn't really want another baby. It was awfully sad.<sup>87</sup>

Mima Sutherland, working in Aberdeen in 1931 had a similar experience with poverty but also found herself helping out the medical student as well.

Some of the homes were very poor. One woman had nothing but a pile of Radio Times and when I went downstairs the wifie gave me some clothes for the baby. I had a [medical] student with me too - we often had them. They sometimes came from abroad. Usually a midwife there supervised the student and also had to subsidise the student's bus fares They didn't have a maek (ha'penny).<sup>88</sup>

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<sup>85</sup> LR, 31 [35].

<sup>86</sup> LR, 19 [47].

<sup>87</sup> LR, 22 [50].

<sup>88</sup> LR, 5 [56].

Molly Muir in Edinburgh in 1934 wondered about lack of neighbours in one particular instance. She said

I went to a case one night in the middle of the night in the High Street and it was their thirteenth child and they had one room. He was unemployed and this was their thirteenth child. They had two double beds in that one room and they all slept in that room and while I was dealing with the birth the father got the others up and took them out just to walk the streets... I often wondered since then why they didn't have neighbours who might have helped them at a time like that.

Yet she showed how equipment could be supplied.

We took... a rubber draw sheet and we put that under the mother to deliver the baby and then in this particular house they only had one [bentwood] chair... I bathed the baby in a baking-bowl, and then the next morning I had to go up from Simpsons and take clothes for the baby. We used to get clothes handed in, you know people who were finished with them used to hand them into the Simpsons and we could always draw on that.<sup>89</sup>

Agnes Morrison did her district midwifery in the Leith area in 1946 and stayed on for six months practising as a midwife. She 'loved every minute of it'. But that did not blind her to the conditions she encountered and the ability to use whatever came in useful in an emergency.

There was an army technicians' hut in Granton... a camp that had been invaded by squatters and we delivered babies there and, oh it was really terrible conditions... people had just squatted up and got themselves organised in their rooms... There was a communal bath... I remember [being] called to a case in this camp and you went into the room where they lived and everything was happening in there and there was a mother in labour. In the cot were two little ones and here was this third one. And she was twenty something. She looked like forty something, poor woman. I can see father yet, sitting over the far end, and I remember he was a painter on the Forth Bridge. You know, I was getting so annoyed with him. I felt this – what a situation to be in. She had her baby and they were all right. Then... she haemorrhaged... and I was giving ergometrine and trying to get the uterus [to contract] and she was going into shock and I said, 'Could you get me some heat, hot water bottles?' 'Oh no.' I said, 'Any beer bottles?' 'Oh yes.' I said, 'Well fill them up with hot water, as much as it will stand and bring as many to me.' I can see me packing beer bottles round this woman to give her heat... [I was there] by myself. It was a terrible situation until I could get her stabilised. Again, we were just called at the last minute... I'd never seen her before... No

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<sup>89</sup> LR, 13 [46].

antenatal care, here she was struggling with two other little ones and...she had about two army blankets I think, you know those grey things, nothing, no comforts.<sup>90</sup>

Agnes Morrison also remembered happier homes.

And then further on in Newhaven, a lovely little fishing village, and I remember a baby there and still the little old cottage type house with the brasses absolutely shining on the fire, the mantelpiece and all the baby's clothes being aired over the brass thing above the range. That was lovely. There was something very nice about that – a wild night outside and the cosy little cottage you were in, and the baby.<sup>91</sup>

She also remembered very clearly the one stillbirth she had on the district, probably resulting from no antenatal care and an inexperienced doctor sent out to help.

I lost one baby on district...the pupil midwife...had called somebody and I was...sent. And it was a breech presentation. So immediately I phoned into the Simpson to get medical help. Unfortunately they sent such a junior little person who did what we were never taught to do. He got on to the feet and the arms shot up you know, and therefore we had the head and two arms to pass through the birth canal. And he, he, was getting into a [state]. You know, I hate to tell you, but I said, 'Would you mind just letting me – ' because strangely enough one of the consultants at the Simpson had been conducting a breech presentation and he never turned the babies...I was doing my training and happened to be in the labour ward and he said, 'Would you just come...and I'll show you. Never rush a breech presentation.' And I'll never forget, step by step he showed me what to do and how to go up and bring the arm down one at a time and gently. But too much time had been lost. It was dead. I knew I was going to deliver a dead baby...but we were more concerned about getting the baby delivered by that time...But when I think of all the situations we were in, to lose only one, I was amazed.<sup>92</sup>

Midwives and doctors were bound within a hospital hierarchy no matter how junior the doctor was. By taking over from the doctor Agnes Morrison's concern at what was happening broke the boundaries of convention. Yet by saying 'I hate to tell you', all those years later she still felt that she had to excuse her breach of etiquette. However, in doing so she also displayed the confidence of midwives of the time on the district.

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<sup>90</sup> LR, 31 [35].

<sup>91</sup> Ibid.

<sup>92</sup> Ibid.

Anne Chapman practised in Glasgow in the early part of World War II and also worked with women in very poor circumstances. She was the only midwife who talked to me about 'the dunnies'.

These people were travelling people and they would travel around in caravans. Most of them had quite big families and they couldn't get a place to stay in the winter. They came back to Glasgow and their caravans would probably be put on Glasgow Green or wherever, and they got the dunny down underneath the tenements. You went in the tenement building and instead of going up you went down. The dunnies were mostly empty in the summertime. Every tenement had them. The dunny was the whole stretch of the tenement underneath with no division, just long areas under the tenements with trodden earth floors. The people would just move in. Some of them had sacking and they could put up sacks or whatever they had to curtain it off a bit. It made it a wee bit more private. There would be one family on one side and another family on the other side. When you went to deliver them you just used any thing you could get. Sometimes the babies were delivered on to a heap of rags. If they had a camp bed they were considered posh.<sup>93</sup>

Some travelling people were not so overtly poor.

And then you had the caravans on Glasgow Green. We were often there. They were in a different street of course and oh they were clean, my goodness I used to wonder how they kept them so clean. But I think the particular caravan you delivered the mother in was just kept special.<sup>94</sup>

Thus, whatever midwives carried with them in the way of equipment, when it came to the environment within which they had to work, they had to accept and make the best of what was there.

### **Midwives' equipment**

Midwives on the district carried most of their equipment with them. In the days before midwives had cars, this involved carrying what they could while walking, cycling or using trams and buses. Their loads were often heavy and awkward.

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<sup>93</sup> LR, 2 [11].

<sup>94</sup> Ibid.



The standard piece of equipment was/is the midwife's bag. Myles indicated the need for two bags particularly for a confinement: 'separate delivery and puerperal bags of metal or leather'.<sup>95</sup> With variations, a midwife's bag for delivery in the early twentieth century contained: an enema syringe, catheter, bath and clinical thermometers, disinfectant soap, nail-brush, biniodide of mercury, lubricant, safety-pins, scissors, tape-measure, cord-thread/tape, ergometrine, chloral hydrate, sal volatile, measuring-glass, syringe and needles, cotton-wool, lint, permanganate of potash, suturing materials, clean aprons, mackintosh sheeting and apron, note-book and copying-ink pencil, four-hourly charts, scales for infant weighing.<sup>96</sup> While these requirements were modified over the years the basics remain the same.

Nearly every midwife I spoke to mentioned her bag. No midwife on the district then, or now, went without it. Working in the 1920s Ann Lamb spoke about her 'brown bag' and Moira Michie from Aberdeen stressed the importance of her howdie grandmother's bag.<sup>97</sup> James Tweedie wrote about his grandmother, howdie at Douglas (later renamed Happendon), from 1877-1923. When she was called out to a tinkers' camp the bag was the first thing she picked up.

In case the lass was in distress,  
Gran took her black bag from the press  
And off on that frosty morn she went,  
To help the wife in the tinker's tent.  
And there in the moonlight's fleeting beam,  
The bairn was born and washed in the stream.<sup>98</sup>

<sup>95</sup> M Myles, *A Textbook for Midwives*, 4<sup>th</sup> ed, (Edinburgh and London: E and S Livingstone Ltd, 1962), p 654.

<sup>96</sup> J K Watson, *A Complete Handbook of Midwifery for Midwives and Nurses*, 3<sup>rd</sup> ed, (London: The Scientific Press Limited, 1914), pp 139-141.

<sup>97</sup> LR, 19 [47]; *Written communication*, LR, [3].

<sup>98</sup> *Written communication*, LR, [42].

Bags, used every day, had to be re-packed every day. Agnes Morrison, working in Leith in the 1940s, said

We had our...bags which we picked up...[when] we came in...we had to do them all up and sterilise stuff and pack them all again...every day. We took it whether we were doing postnatal or whatever and then it was up to us to have it all cleaned out, things sterilised [and] boiled up...we might have to do it mid-day [as well].<sup>99</sup>

Pupil midwives on the district had to have their bags inspected before they went out.

Linda Stamp, in training at Rottenrow in the 1940s recalled this and also how they made special cords for tying the umbilical cord which they kept in the bag.

To make the umbilical cords we had very fine thread just like string. It was very white and it had to be a certain length and we had so many taped together... The sister there was pretty old and supervised what we took out with us. She inspected our bags before we went out. She was very very fussy. We took all that was essential. We had our sterile things in little packs. They weren't really sterile packs of course at all but they were washed and clean and clean towels and the umbilical cords.<sup>100</sup>

But certified midwives also had their bags inspected by the SOM. Mary McCaskill said

'You had your bags inspected regularly...not any longer a period than three months between the inspections, but not as often as every month'.<sup>101</sup>

The bag was looked upon as a passport, for instance to the top of the queue for the Glasgow trams, and Margaret Dearnley recalled,

You wore your uniform, you're carrying your bag. And if you went to stand in the tramcar line...they would say 'Oh,' - great big queues of people of course - 'Here's the nurse, some puir sowl's waitin on her comin.' And you were pushed up the line and they let you on. And the driver would say... 'Where are you going nurse?...They would stop at the close that you wanted to go to. Wasn't that fantastic?'<sup>102</sup>

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<sup>99</sup> LR, 31 [35].

<sup>100</sup> LR, 4 [115].

<sup>101</sup> LR, 35 [27].

<sup>102</sup> LR, 1 [20].

Anne McFadden remembered how her midwife's bag gave her a clear passage in 1940s Edinburgh.

The whole culture was quite difficult. You could call them the drug addicts but it wasn't the kind of drugs we know about... They used the gas fittings [from lamps] and the methylated spirits and they were lying asleep down the Vennel Steps down into the Grassmarket. But, they were so respectful, whenever they saw a black bag, up they got... and said... 'Sorry, nurse, let you pass'... And you had your black bag with you.<sup>103</sup>

Another important piece of equipment was the delivery pack or box. One midwife at the beginning of her midwifery career in the late 1930s said,

first of all... we made up these packs and I had a gown and masks and bonnet and cotton wool and swabs but then latterly the boxes came all ready and you just opened it in the house. But, you know, it was amazing, you had children there and we wrapped this up in brown paper and put it up on top of the cupboard. Nothing was ever touched, nothing.<sup>104</sup>

Sterile delivery packs were supplied free to mothers at a cost (in 1951) to the LA, of 18/6 (92 ½ pence) each, on condition the pack was opened only by the midwife or doctor and if not used, it should be returned unopened.<sup>105</sup> The administration differed from place to place. Mary McCaskill recalled the procedure in 1940s Glasgow.

If the mother was booked to have a home confinement, she got the pack... from the central office... at about thirty-six weeks. She'd go with a chitty from me and collect that pack. She didn't have to pay for it... [I carried it to the house]... if it was an unbooked or emergency delivery. You kept say four or maybe six packs in your own home so that you could produce them during the night when the central office would be closed... There would be a sterile sheet for delivery and... there would be swabs, and there would be sanitary towels but I can't really remember what else... the midwife carried the Dettol.<sup>106</sup>

<sup>103</sup> LR, 36 [108].

<sup>104</sup> LR, 23 [99].

<sup>105</sup> Dressings for confinement and lying-in period, DHS Circular no 84/1951, 8 August, 1951, notes belonging to Miss Isobel Duguid, RGN, SCM, MTD; Myles, Textbook for Midwives, 4<sup>th</sup> ed, p 653.

<sup>106</sup> LR, 35 [27].

However Anne Bayne in the 1950s had a different story.

The most common thing that happened everywhere, after thirty six weeks [of pregnancy], you went in and collected your brown box [and took it to the mother]. This was the delivery box and in it was waterproof paper, cotton wool, sanitary towels and so on - and a bottle of Dettol. Well, the Dettol in Glasgow was always white! 'We got it like that Nurse. That was how it came.' Of course they had used the Dettol and filled it up with water and of course when you put water into Dettol it turns white. So all we finished up with was this white Dettol.<sup>107</sup>

When the baby was born the midwife delivered the placenta which had to be disposed of. In most areas the midwife examined the placenta and if it appeared complete wrapped it in newspaper and burnt it on the fire. However Rottenrow pupil midwives were required to take the placenta back to the hospital for examination. As Ella Banks recalled, this involved an unusual piece of equipment.

We had to have a sponge bag and in that sponge bag, you had to put the placenta and bring it back to the hospital to be checked to see that it was complete and healthy. The sponge bag had strings that you pulled across. And you put your placenta in there and took it back to the hospital.<sup>108</sup>

Her friend Linda Stamp added,

I don't know of anyone leaving it on the tram but one time the cat ran off with the placenta - this was my friend's placenta. She ran after the cat and she did get some of it, but not very much.<sup>109</sup>

However Anne Bayne in the 1950s also recalled the ritual of returning the placenta to hospital but in another container. Although not a Rottenrow pupil herself she found herself helping a pupil midwife from Rottenrow who had left her placenta on a bus in a National Dried Milk Tin. They had to go to the Bus Depot and retrieve it.<sup>110</sup>

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<sup>107</sup> LR, 21 [91].

<sup>108</sup> LR, 3 [2].

<sup>109</sup> LR, 4 [115].

<sup>110</sup> LR, 21 [91].

Midwives had another heavy piece of equipment to carry after 1946 when the CMB allowed midwives to administer gas and air on their own responsibility. This sometimes meant carrying the Minnitt apparatus with them as well as everything else. Mary McCaskill recalled,

We had a portable Minnitt machine. [The cylinder and the machine] were all in the box together. It was quite heavy even although it was portable... quite often we would ask the husband if he would carry [it].<sup>111</sup>

However bulky, heavy and awkward the equipment, it was necessary for successful domiciliary midwifery. In 1959 the CMB responded to a complaint about the weight of equipment a midwife had to carry by justifying the need for all the articles in the bags but said that employing authorities should provide adequate transport.<sup>112</sup> Before this, in some areas taxis were used and Mary McCaskill described what happened in Glasgow from the early 1950s.

Somewhere between eight and nine at night till six o'clock in the morning, Glasgow Corporation provided a car and a driver... If it was during the hours of darkness he would come to my house and take me to where the confinement would take place and then he would come to the house and bring me [home].<sup>113</sup>

This seemed to be common practice as Margaret Dearnley corroborated.

If you were beyond the tram route or very far away or it was very early in the morning you got the green car, the town car... You phoned in to say you were leaving, where you were and it was two o'clock in the morning you had to go back to Rottenrow, so they sent a 'green caur' as they talked about which was the... town limousine.<sup>114</sup>

This did not always solve the problem. Many midwives walked, cycled or used public transport when it was available, or, on some memorable very early-morning occasions

<sup>111</sup> LR, 35 [27]; Myles, *A Textbook for Midwives*, 4<sup>th</sup> ed, p 270. The Minnitt-minor apparatus for nitrous oxide-air analgesia in domiciliary midwifery practice weighed 12.5 lbs; for further discussion on midwives and inhalational analgesia see chapter 4, p 130.

<sup>112</sup> NAS, CMB 1/7, *CMB Minutes*, 12 March, 1959, p 1.

<sup>113</sup> LR, 35 [27].

hitched a lift on the back of a refuse-lorry. Anne Chapman in Glasgow in the 1940s recalled,

We had to walk everywhere... We used to stand up on the back of a refuse cart and get a lift... If the driver saw us he would stop and yell, 'Where are ye goin?' and he would take us... 'Jump on'. And there we were clutching on the back – the student and I. Rattling away and then he would shout, "What street are ye goin to?" These men were great.<sup>115</sup>

The 1949 Working Party on Midwives highlighted the problems of inadequate transport endured by midwives on the district and recommended the provision of a car for every midwife, financial help to run it and assistance with driving lessons.<sup>116</sup> Eventually it was a condition of the job that community midwives should be able to drive and LAs either supplied a car or assisted midwives either to buy or lease cars thus helping to solve both transport and equipment problems.

### **Relationships and policies**

An important difference between caring for labouring mothers at home or in hospital is the contrast in relationship between midwife and mother. Until at least the 1980s, when a mother went to hospital, she entered an environment in which she had to relinquish authority. At home the mother and her relatives retained and still do, the status of host and all pupil/student midwives were and are taught to respect this before going into the community. This contrast has become less marked since the 1990s with the publication of the Provision of Maternity Services in Scotland: A Policy Review. This Review recognised that some aspects of maternity care were unacceptable and advocated more informed choice for mothers, and woman centred care leading to different attitudes in

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<sup>114</sup> LR, 1 [20].

<sup>115</sup> LR, 2, [11].

hospitals/maternity units from members of staff, collectively through changed policy and individually through personal actions.<sup>117</sup>

To work as a midwife on the district in the 1940s included an acknowledgement of the particular respect owed to a mother and her relatives in their home. Anne Chapman demonstrated this clearly when she recalled visits to gypsies. She said

I used to go to lots of gypsies' tents and caravans out in the rural areas. They always had dogs... Once I went to a quarry... There was just one entrance into it and they had tents all round. There was a dog's kennel at one side of the entrance and a dog's kennel at the other and two of the most ferocious Alsations I have ever seen in my life... They were tied so they couldn't meet each other but you could never have passed through this small space between them. I was terrified. The first time I went I was on my bicycle... I called and I shouted. Somebody was supposed to be in labour.

Finally Anne sent some children for their granny. She said

The granny appeared and one word fae her and these dogs went slinking into their kennels. I couldn't believe it. And then she said, 'Noo nurse come on, bring yer bike. Somebody might lift it leavin it there.' This was me on my own in this old old quarry... and a big fire in the middle where they did their cooking. These dogs were really ugly. They were still howling and barking... but one word from her and they were away.

Through controlling the dogs, the granny retained control of the situation. The second reminder of who was host came after the baby was born.

When the baby was born and everything was grand the granny said 'ye'll need tae get a cup o tea'. And it was out of a tin can. But you never said no because you wouldn't want anyone to think you were feeling a bit uppity. They were always so grateful and always wanted to give you tea or whatever they had. And there was always the camp fire... with the kettle or tinnie on the boil. One time I had delivered the baby... the mother had been given a syrup tin of tea and the grandfather who was really proud of the bairn, turned and said to me, 'A drink o tea. Ye'll tak it.' Well I couldn't refuse. 'Hae a seat.' I sat down on the ground and was handed a tinnie of tea with a handle. But the tinnie had been on the fire

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<sup>116</sup> Working Party on Midwives, p 57.

<sup>117</sup> SHHD, *Provision of Maternity Services in Scotland: A Policy Review*, (Edinburgh: HMSO, 1993); E Hillan, M McGuire and L Reid, *Midwives and Woman Centred Care*, (Edinburgh: RCM Scottish Board, and University of Glasgow, 1997).

and my mouth was badly burnt. Well, I never said a word. But by the next day I had to report to Sister. I couldn't go out because of my sore mouth.<sup>118</sup>

Here, Anne Chapman conformed to the rules of being a guest in someone's home even though she was there professionally.

Anne Bayne had another unusual experience which would be unlikely to have happened in hospital and which demonstrated the need to fit in with the customs of the home. At the time (1951) she was a pupil midwife at Lennox Castle and doing Part 2 on the district in Glasgow with the Green Ladies. She said that she had been looking for this woman in labour for some time and

Eventually I knocked on a door and when... I went in I could hear definite labour pain... There she was on the bed which was, as usual in the corner. There was the most amazing mat on the floor. It had strange signs on it and round it were all these men – they must have been Sikhs. Their turbans were off and they all had long hair and they were praying. Well I stood at the door... and I thought, she's going to deliver... what do I do here?... They must have known that I had come in. So I... just went for it. I got half way across this mat and they whipped it from under me and I landed on my back with my feet up. One of them was leaning over me – I can see his long hair yet... He was saying, 'You damned, you go to hell. You damned you go to hell'... At that point I would have quite liked to have been in hell... However I picked myself up with what dignity I could and I went across to her. She didn't speak. Well, they all just stayed there. I thought, if anything goes wrong with this delivery, I am for it... The Green Lady hadn't arrived. I prepared as best I could. I can't remember that much. A woman appeared at the door with water. They knew the drill. I delivered this baby. As soon as I delivered the baby, these men took the baby from me... I came out of there shaking like a leaf.<sup>119</sup>

Thus, Anne Bayne, by crossing the prayer mat (with the best of intentions) to get to the labouring mother, transgressed the cultural mores of the home she was in and paid the price by undergoing a frightening experience. In contrast, Anne Chapman (above) conformed by drinking tea out of a hot tinnie, burning her mouth and having the grace not to mention it to her host.

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<sup>118</sup> LR, 2 [11].



When a woman went to hospital to have her baby she had to conform to the mores and policies of the hospital. One example of this was the use in some hospitals of what was known as 'the slab'. Professor R W Johnstone made clear the passivity expected of the mother on the slab in his article describing the 'new Simpson' which opened in 1939. He wrote, 'she [the mother] is taken up by ... a lift to the first floor where the main delivery suite is situated. She goes first to a reception room where her clothing is removed; thence to a bathroom where she receives a warm spray bath on a shallow porcelain slab.'<sup>120</sup> Washing mothers on 'the slab' on admission was one way of preventing cross-infection. However the way that hospital policy decreed staff should perform this task took authority from the mother and put it into the hands of, not an individual, but the policy-makers. Collectively, members of staff appeared to obey policy. Individually they had doubts about what they were doing. Margaret Foggie remembered the slab in Rottenrow in 1934.

Another thing they had at Rottenrow...when they [the mothers] were admitted to the first place and it was called the slab...they undressed them and hosed them down on this concrete slab before they were allowed further. It was awful...having a woman undressed and being hosed down. They would then have a clean nightie put on.<sup>121</sup>

The slab was still at Rottenrow when Peggy Grieve was there as a pupil midwife in 1946.

She described what happened then.

The slab was the admission room and there was...this old ...midwife...in charge... She was a tartar. Very often she would ...have a student with her and the patients would come in there – some of them had had no antenatal care... They just arrived and they were stripped of their clothes.... And they would be washed, I think some of them needed it but that was it. It was called the slab because there was just a slab...of formica you know like a work surface...I think there were two of them – two slabs...[in this] sort of square room. They were

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<sup>119</sup> LR, 21 [91].

<sup>120</sup> R W Johnstone, 'The Simpson Memorial Maternity Pavilion', pp 1022.

<sup>121</sup> LR, 22 [50].

literally put on to the slab. There was a sheet on it but that was all... They used to whip the sheet off it if somebody came in pretty dirty... This was them coming in in labour. Even if they came in pushing they didn't bypass the slab. Sometimes they had a delivery in the slab. They put them into these hospital gowns... that opened down the back and they had red dressing gowns and they could have a red sort of cape thing when they were sitting up in bed. They got that in the slab<sup>122</sup>

Thus, the use of the slab exemplifies the way hospital policy, made for a good reason (in this case the reduction of infection), put midwives and student-midwives into the difficult position of subjecting women to prescribed procedures.

As the ratio of home to hospital births changed, more midwives were employed in the hospitals and correspondingly fewer on the district, or 'in the community'. More midwives therefore found themselves having to conform to policies which took away their decision making abilities as well as their practical skills. Caroline Flint wrote of the effects of working inside an institution, how she lost confidence in herself as a midwife, in women's ability to give birth. She blamed the concept of the institution which represented illness and pathology for encouraging midwives to behave differently from outside the hospital. In addition, she argued that hospital policies and procedures took away the expertise and decision-making skills of the midwife.<sup>123</sup>

Mary Cronk a practising midwife, wrote about her view of the midwifery profession since 1948. She stressed the rapid change in midwifery practice which took place in the 1960s, the impact of the Peel Report of 1970 already mentioned, and the corresponding 'growth in number, strength and power of the emerging profession of obstetrics'. She wrote,

By 1975 I was not practising as a midwife, I was delivering babies according to a preset series of instructions. I was not exercising clinical judgement, and as long

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<sup>122</sup> LR, 16 [102].

<sup>123</sup> C Flint, *Sensitive Midwifery*, (London: Heinmann Midwifery, 1986), pp 131-132.

as I did what I was told, I was 'covered'. It was easier to just accept it, and get on with it, trying not to think too hard about what I was doing to women.<sup>124</sup>

One midwife, who wishes to remain anonymous, was so upset by what she and other student midwives had to do to labouring mothers in 1976 in a hospital in Scotland that she nearly gave up midwifery altogether. She explained,

At this time all the women had...to have artificial rupture of membranes and syntocinon on the day that they were due to have their baby. I remember... working with these women... Induction was always by artificial rupture of membranes... I remember women queuing up to go into a labour room to have their legs put up in stirrups, to have artificial rupture of membranes done. I remember some women screaming because...the cervix was not ready... After this they were taken back to their four-bedded rooms and they were attached to a syntocinon drip right away and it was turned up at regular intervals, so it was increasingly painful, with minimal pain relief... They were all on their beds. They were not allowed to walk around. [They were] all either crying quietly... moaning and groaning. We just had to do the clinical observations and move on to the next woman. You didn't have time to do the caring that is part of midwifery. It was awful...

[There were]...four single rooms and one double delivery room and by two o'clock in the afternoon, you were delivering without even gloves on because the babies were popping out all over the place and there just wasn't enough staff to deal with this... You were not allowed to take the women to the labour room until they were actually in the second stage of labour which meant that they got minimal pain relief. It also meant that when they were wishing to push you had to say 'Don't push! Get off the bed and on to the trolley.' You had to get them on to the trolley and...through at least three or four sets of double doors having previously phoned the labour ward to make sure that there was a labour bed available and then you had to get them into the labour ward before they delivered their baby, and woe betide you if they delivered on the bed or on the trolley... It was such a nightmare that by the end of three months I thought of giving up. And then I thought, No, I don't give up that easily. I'll get to the end of this. I just felt that this wasn't the way to treat women and I really didn't want any part of this... There was no caring.<sup>125</sup>

Professor Sir Malcolm MacNaughton offered some justification for increased induction of labour rates in the 1970s. He said that one of the major causes of perinatal mortality in Glasgow which in 1970 was 28/1000, was 'mature unknown deaths which were usually

<sup>124</sup> M Cronk, 'Midwifery: A Practitioner's View from within the National Health Service', in Midwife, Health Visitor and Community Nurse, Vol. 6, No.3. March 1990, p 61.

those between thirty-eight and forty-two weeks. We therefore made some changes in policy such as more induction of labour, and in 1974 there had been a reduction in the number of those late deaths.<sup>126</sup> However this justification does not explain the indiscriminate policy described above.

Another example of sweeping use of hospital policy was the performance of episiotomy. From 1968 the CMB Rules permitted midwives to perform episiotomies and revised the syllabus to this end for student midwives.<sup>127</sup> Although initially obstetricians did not approve of midwives performing episiotomies, by the mid-1970s in some maternity units it was policy that many women should have an episiotomy.<sup>128</sup> The midwife quoted above said,

‘every woman, whether they needed it or not had...to have an episiotomy. Some of the time I would not have recognised that there was a need but it was what had to be done and even if you were delivering unsupervised it had to be done. You weren’t allowed to say, ‘No I’m not going to do it’.<sup>129</sup>

Mary Cronk, practising in England in 1976, epitomised the feelings of many midwives when she wrote,

My own first confrontation came over the episiotomy issue...All primips...and all previously sutured perineums had an episiotomy. Colleagues who knew my views, said things like, ‘we have all got to do it, when in Rome...If you feel like that, drop the scissors on the floor, or say you didn’t have time, but don’t rock the boat’. I then observed a colleague when working with a student, make an episiotomy after the delivery of the head, so that she wouldn’t get into trouble with the consultant...What was happening to my profession finally dawned on me. All these issues ...were about the same thing,, our right to practise, to make clinical judgements...and to be accountable for that judgement. Consultant

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<sup>125</sup> LR, 20 [85].

<sup>126</sup> M MacNaughton, Mabel Liddiard Memorial Lecture: ‘Perinatal Mortality in Scotland’, in *Midwives Chronicle*, March 1992, p 47.

<sup>127</sup> *CMB Rules*, 31 March, 1968, p 11; M Myles, *A Textbook for Midwives*, 7<sup>th</sup> ed, (Edinburgh and London: Churchill Livingstone, 1971) p 618; *CMB Report* 31 March, 1969, pp 3-4: The CMB did not make hospital policy, although there was often vigorous interchange of views between maternity unit management committees and the CMB.

<sup>128</sup> NAS, CMB 1/8, *CMB Minutes*, 20 February, 1969, pp 1 and 4.

<sup>129</sup> LR, 20 [85].

obstetricians can provide guidelines... but as a practitioner the midwife has a duty to provide the best care possible to a mother and baby... and that care cannot be predetermined.

I studied the rules of the... CMB and at the next birth I attended I did not make an episiotomy and informed the consultant that if he wanted to make a complaint about my practice he should [do so] to the CMB. He didn't.<sup>130</sup>

Here Mary Cronk shows how midwives did not like adhering to a blanket hospital policy but were afraid to 'rock the boat'. It took bravery to stand up to the consultant. However, she indicated that progress had been made for midwifery when she wrote, 'I remember to this day, how I shook, and how terrified I was. It seems ridiculous now when we have fought and won so many battles over our rights to practise'.<sup>131</sup>

Two midwives who practised in both Scotland and England spoke to me about their experiences. Both remarked on the difference in midwife: doctor relationships between Scotland and England with a subsequent impact on midwifery practice. Margaret Kitson used the specific example of episiotomy to illustrate a general attitude. She returned from training and working as a midwife in England to Scotland in 1965 and commented,

There seemed to me south of the border to be a much more relaxed attitude. And there was also a greater willingness to allow midwives to be – this famous phrase – independent practitioners. When I first came to Scotland to work as a midwife... one of the first... deliveries that I conducted resulted in sudden and serious fetal distress just at the end of the second stage. Without a thought I made an episiotomy because I had been trained to do it. That is what I would have done in England. And the furore there was about that. How had I dared to do that?... I had actually immediately sent for the doctor – but why had I not waited until the doctor appeared? My reason was very simply that I did not want that baby to die and I knew what I was doing and I simply went ahead... Now, in England that was perfectly acceptable and up here I felt as if my hands were *tied*.<sup>132</sup>

<sup>130</sup> Cronk, 'Midwifery: A practitioner's view from within the National Health Service', p 61; there is nothing in the relevant CMB Rules to say that midwives should obey hospital policy without question.

<sup>131</sup> *Ibid.*

<sup>132</sup> LR, 41 [120].

Margaret Kitson commented on the attitude of midwives in Scotland to their own profession and said,

there was an unwillingness at that time, amongst the middle and senior managers in midwifery to accept that midwives could form judgements based on knowledge and experience which could lead to action which was perfectly acceptable.<sup>133</sup>

And described their deferent attitude to members of the medical profession:

The doctor was the next thing to God...I respected my medical colleagues...and they had skills and experience I certainly didn't have and I didn't want to usurp them but I had skills too...and not just me – the midwives round about me, but they were terrified to use them because somebody was going to come down on their head and say, 'You're not supposed to do that.'<sup>134</sup>

She felt there was a distinct difference between midwifery practice in Scotland and England and gave some reasons why this might be.

I think it was partly cultural. I think there is or there was a greater deference to medical staff in Scotland – not just obstetricians, but all medical staff in Scotland than there was in England. So I think it was partly cultural...and partly historical.<sup>135</sup>

Gelda Pryde who practised midwifery in Nottingham before returning to Scotland in the 1960s also spoke about Scottish midwives' attitude to doctors.

I had been doing all these things [extended midwifery procedures] in England and then I came back to Forth Park and I just couldn't believe the difference because the midwives were very much ruled by the medical staff there and it took me a long time to make myself stand back.<sup>136</sup>

She suggested that a cultural lack of confidence affected their practice and emphasised the difference in attitudes she had noted.

I don't know whether it's something to do with the midwifery training but they certainly lacked, when I came back, and I think still to a certain extent, they lacked the confidence to discuss patients on an equal with doctors. Something would start to go wrong and they would call the GP in and ten minutes later, the

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<sup>133</sup> *Ibid.*

<sup>134</sup> *Ibid.*

<sup>135</sup> *Ibid.*

<sup>136</sup> LR, 42 [69].

GP would be away...and they would phone me saying, 'I'm so worried because doctor says such and such and I don't think that's right.' 'Well, did you say that you weren't happy?' 'Well but the doctor said – 'And that was something I couldn't come to terms with...It was very much...' 'The doctor said', in Scotland and you didn't ... say, 'Well I'm sorry I don't agree with you and I'm here observing the patient 24 hours a day and you're only paying a flying visit so I think my opinion is as valid as yours, if not more so.' I don't know if it was anything to do with their training or whether Scots are just naturally a bit more reluctant to stand up and be counted. Even when...we went to Nottingham to start our training...we were the only two Scots there – and the girls in our group were all from English hospitals...And they all seemed to have much more self-confidence than we had. We sort of stood back whereas they were always in there.<sup>137</sup>

Margaret Kitson offered another explanation which could have added to the growing medical domination in the 1950s and 1960s.

There had been in the fifties and...into the sixties a recruitment difficulty in nursing and midwifery. The result...was that there were some nurses and midwives whose basic education...[was] not...as good as it might have been. The big training schools in Scotland were still able to recruit students who had good...scholastic education qualifications, but some...hadn't been able to do that. The result was that they recruited people with somewhat limited educational ability. It was easy then for medical domination to take over...I really do think that that was a factor. It was something we suffered from again in the seventies and there is always a temptation when recruitment is difficult, to reduce standards and it's a mistake. It just does not work. And...the profession is left with the results of that for a very long time, for the working lives of the people who have been recruited. Now some of these people, actually rose above their initial deficit because [it] was the result of lack of opportunity, not lack of ability...But it was very difficult for others and it was very difficult for the people of ability to pull these souls up. I think that was a big factor and one that tends to be forgotten.<sup>138</sup>

Thus, there were many inter-twining strands of relationships, policy, culture and history with which midwives had to cope within the practical business of caring for a mother and delivering her baby.

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<sup>137</sup> Ibid.

## Conclusion

The issue of where and how women having a normal labour should give birth is a continuing one. This chapter has attempted to show differing situations in which mothers gave birth and the midwife's role within each. It has also revealed that under the peculiarly Scottish 'Maternity Services Schemes' which developed from the 1915 Notification of Births Act, LAs were given power and control over maternity care from an early stage. Doctors had official control over births in Scotland even though they were not necessarily present at the delivery of the baby. This put midwives into an uncomfortable position. On the one hand they were legally autonomous practitioners. On the other, they were subservient to the medical profession and, as some have argued, deference to doctors was greater in Scotland than in England.

As the trend towards hospital births grew, the midwife's position became more tenuous. In the home situation, her position was more clearly defined. Within the hospital labour ward, even though midwives delivered most of the babies, there was a blurring of roles between midwives and doctors. The accounts of midwives in this chapter confirm Rosemary Mander's writing about midwives' autonomy: 'whereas the midwives correctly saw themselves as autonomous in caring for mothers experiencing normal childbirth, the medical staff saw themselves as having overall responsibility and being able to exercise that responsibility as they saw fit.'<sup>139</sup> In some circumstances doctors took over entirely as one midwife recounted: 'a great emphasis was put on what the doctor said, what the doctors wanted and how it was going to be. The women themselves were

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<sup>138</sup> LR, 41 [120].

<sup>139</sup> R Mander, 'Autonomy in Midwifery and Maternity Care', in *Midwives Chronicle*, October, 1993, pp 369-374.



not considered and what they wanted wasn't considered. Nobody said they did not want to be induced'.<sup>140</sup>

The change from home births to hospital meant that the bugs and fleas were washed off at 'the slab' and clean sheets replaced newspapers. Women welcomed the respite from household chores which the hospital provided. At the same time the judgement and autonomy of midwives who demonstrated their skill and resourcefulness in the conditions of extreme poverty they faced in providing domiciliary care, was limited and frustrated. Women were subject to unnecessary procedures like indiscriminate induction of labour and episiotomy to conform with hospital policy. As the effects of medicalisation of childbirth became more evident, midwives found themselves in the dilemma of obeying hospital policy and protocols rather than being autonomous midwives and advocates to mothers.

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<sup>140</sup> LR, 20 [85].

## Chapter eight

### Postnatal care

Postnatal care has been a long-standing and important part of a midwife's work. Like intranatal care, midwives' care of mothers and babies in the postnatal period has been recognised since the first complete set of CMB Rules.<sup>1</sup> There are two terms which may be used to describe the time immediately after birth. One is the 'lying-in period'; the other is the 'postnatal period'. The 1918 CMB Rules stated that 'the lying-in period...shall be held...in a normal case, to mean the time occupied by the labour and a period of ten days thereafter'.<sup>2</sup> However, later in the Rule book, the term 'lying-in' was used separately from 'labour'. Therefore, for the purpose of this chapter which deals with midwifery practice during the time after birth for a period of ten to fourteen days, I shall use the terms 'lying-in' and postnatal' interchangeably. The postnatal period differs from the longer puerperium which is defined 'as the period from birth until six weeks after the baby is born. During this time [the puerperium] the reproductive organs return to their pregravid state, lactation is established and the woman recovers from pregnancy and childbirth.'<sup>3</sup>

This chapter explores aspects of midwifery practice during the postnatal period. This is a wide field encompassing care of both mother and baby. Because of this I have decided not to include specific issues such as care of the umbilical cord, breast *versus* bottle-feeding and rooming-in, all of which reflected changing customs over the years.

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<sup>1</sup> NAS/CMB 4/2/9, CMB Rules, 26 August, 1916, p 9, para 12.

<sup>2</sup> CMB Rules, 31 March, 1918, p 20.

<sup>3</sup> M McGuire, Community Postnatal Care Provision in Scotland: The Development and Evaluation of a Template for the Provision of Woman Centred Community Postnatal Care, unpublished PhD thesis.

Instead, the chapter includes an overview of CMB Rules on postnatal care and why some midwives found it difficult to adhere to the Rules. It also examines the custom of keeping mothers in bed for ten days postnatally and how this changed. With early ambulation of mothers coinciding chronologically with rising hospital birth rates and a shortage of hospital beds, the next step was early discharge home for mothers and their babies. I shall examine this development using midwives' testimonies to show their views. Midwives came across many contrasts in the homes and lifestyles of the people with whom they worked. This chapter also explores some of these contrasts through midwives' voices. By examining these features of midwives' postnatal practice, I shall try to establish how much autonomy midwives maintained in an area of great importance to mothers and their babies.

### **Midwives and the postnatal period: an overview**

From the publication of the first complete set of CMB Rules in August 1916 there has been a statutory requirement in Scotland for midwives to attend upon and examine a mother and her infant for the ten-day postnatal period.<sup>4</sup> The only exception to the ten-day rule was between 1939 and 1965 when the statutory period was fourteen days. There was a similar increase in the statutory period of midwives' postnatal attendance in England and Wales.<sup>5</sup> The increase occurred as a result of a change in the CMB (E&W) Rules after the 1936 Midwives Act applying to England and Wales. This Act and the 1937 Maternity Services (Scotland) Act entitled every woman having a baby to free home visits by a

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(University of Glasgow: 2001) p 23; the CMB did not require midwives to visit the mother and baby for the full puerperium.

<sup>4</sup> NAS, CMB, 4/1-5, CMB Rules, 26 August, 1916, p 9.

midwife in England and Wales for a stated period of fourteen days and in Scotland 'during a period not less than the lying-in period' which the CMB decided to increase from ten to fourteen days.<sup>6</sup> In the 1930s there was much anxiety surrounding the MMR and the 1936 and 1937 Acts were framed as a response to this. During the lying-in period the CMB expected midwives 'to visit the patient twice a day for the first three days following delivery and at least daily thereafter for a minimum period of ten days, or for as long as her expertise is required'.<sup>7</sup> The equivalent CMB (E&W) Rule was the same except for intermittent attendance of a midwife from the tenth day up to the twenty-eighth day postnatally.<sup>8</sup> Thus, in Scotland, the midwife decided whether it was necessary to carry on visiting after the tenth day. Reasons for continuing visits could include: excessive or offensive lochia in the mother, in which case the midwife called in the GP; feeding problems; and non-separation of the umbilical cord. Fay MacLeod practising in the 1960s said, 'Yes, ten days or you visited them till the cord came off. Or if there was any complications like breastfeeding and [problems] like that'.<sup>9</sup> Where necessary, the midwife continued to visit until the problem was resolved.

As the place of birth changed, most women, often in hospital for up to ten days postnatally, did not see the district midwife. More midwives were employed in maternity units and fewer on the district. The role of the midwife on the district, already eroded by having fewer home deliveries and little or no antenatal care to give, was diminished and

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<sup>5</sup> T Murphy-Black, 'Care in the Community during the Postnatal Period', in S Robinson and A Thomson eds *Midwives, Research and Childbirth*, Vol 3, (London and Glasgow: Chapman and Hall, 1994), p 121.

<sup>6</sup> NAS, CMB, 1/5, *CMB Minutes*, 18 March, 1937, Vol. 22, p 8; *1937 Maternity Services (Scotland) Act*, [1 Edw 8 & 1 Geo 6 Ch 30], 1 (1).

<sup>7</sup> *CMB Rules*, 1980, p 10.

<sup>8</sup> *CMB (for England and Wales) Handbook and Rules*, (London: William Clowes and Sons Ltd., 1962), p 40; Murphy-Black, 'Care in the Community during the Postnatal Period', p 121.

<sup>9</sup> *Oral testimony*. For details of the oral interviews conducted in relation to this research, see Appendix 4. LR, 38 [117].

very nearly extinguished by the late 1960s. At the same time the rising number of hospital deliveries and the corresponding requirement for antenatal beds contributed to a shortage of institutional maternity beds.<sup>10</sup> This led to a change in the postnatal care of mothers, with the emphasis on increasing early ambulation and self-care. To cope with these changes, 'early discharge home' emerged in the 1950s and gradually became an accepted part of postnatal care. The need for the district or community midwife slowly re-appeared, but not usually to give full midwifery care. Yet, the number of midwives on the district had declined to a level too low to cope with the number of mothers and in 1965 the CMB reluctantly agreed to an amendment to the 1947 NHS (Scotland) Act allowing health visitors and home nurses to attend mothers in the lying-in period. The Board was not 'entirely happy' that a person other than a midwife should look after a postnatal mother. However it acknowledged that with the current trend for earlier discharge from hospital, this was happening already and the Board felt that it could not oppose this amendment.<sup>11</sup>

The CMB tried to retrieve the position in 1973. The decision was never included in the CMB Rules and by 1973 the membership had changed to the extent that only four members of the 1965 Board remained. It is probable that the newer members were unaware that the amendment to the NHS Act regarding postnatal care had been made. In 1973 the CMB minuted its realisation that health visitors were visiting postnatal mothers discharged early from hospital and it appeared fairly common 'in many areas' for the health visitor to take over from the midwife after the sixth day.<sup>12</sup> In addition, the Board found to its dismay that there were considerable variations in LAs' arrangements for the

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<sup>10</sup> Murphy Black, 'Care in the Community in the Postnatal Period', p 123.

<sup>11</sup> NAS, CMB 1/8, CMB Minutes, 16 September, 1965, p 2.

postnatal care of mother and baby up to the tenth day. Therefore some mothers did not have the services of a midwife for the full postnatal period.<sup>13</sup> In other areas LA midwives were attached to maternity hospitals enabling them to follow up mothers and babies in that area from the hospital until the end of the postnatal period as defined in the Rules of the Board. The Board, in line with the Tennent Report on the integration of the maternity services in Scotland, recommended that where this was not happening, it should be initiated and acknowledged that the re-organisation of the NHS in 1974 which emphasised integration would serve to expedite this move.<sup>14</sup> To dispel any doubt the Board reiterated further in 1975 that 'it was a requirement of the Board that the attendance of a midwife was necessary for the whole of the 10 days postnatal period'.<sup>15</sup>

By 1980, 99.5% of babies in Scotland were born in hospital, and community midwives were employed with a primary remit of giving postnatal care. Midwives on the district, their numbers reduced because of the lowered homebirth rate, were attending postnatally to increasing numbers of mothers having early discharge from hospital. Thus midwives gave less time to each woman although there were many more visits to make.<sup>16</sup> In addition, overall, there was a lack of continuity of care for women. Most antenatal care was performed by GPs and obstetricians, most births were conducted by hospital midwives, and midwives on the community gave postnatal care. This therefore was the only area where community midwives were able to maintain their skills.

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<sup>12</sup> NAS, CMB 1/8, CMB Minutes, 19 April 1973 p 3.

<sup>13</sup> NAS, CMB 1/8, CMB Minutes, 20 September 1973 p 3.

<sup>14</sup> SHHD, Maternity Services: Integration of Maternity Work, the Tennent Report, (Edinburgh: HMSO, 1973), p 14; NBS, CMB Report, 31 March, 1974, p 4.

<sup>15</sup> NAS, CMB 1/8, CMB Minutes, 20 February, 1975, Appendix 1, p 1.

<sup>16</sup> Murphy-Black, 'Care in the Community in the Postnatal Period', p 124.

### Rules on giving postnatal care

Whether a woman gave birth at home or in hospital, the basic postnatal rules for midwives were the same. In the early days of the CMB the emphasis was on physical recovery of the mother, cleanliness of both mother and baby, the establishment of breastfeeding (ideally) and close observance of both mother and baby for any signs of abnormalities when the midwife was bound to call for medical assistance. These included in the case of a lying-in woman:

Fits or convulsions,  
Abdominal swelling and tenderness,  
Offensive lochia, if persistent,  
Rigor with raised temperature,  
Rise of temperature above 100 degrees Fahrenheit with quickening of the pulse  
for more than twenty-four hours,  
Unusual swelling of the breasts with local tenderness or pain,  
Secondary postpartum haemorrhage,  
White leg. (*Phlegmasia alba dolens*).

In the case of the child, abnormalities or complications included:

Injuries received during birth,  
Any malformation or deformity endangering the child's life,  
Dangerous feebleness,  
Inflammation of, or discharge from the eyes, however slight,  
Serious skin eruptions, especially those marked by the formation of  
watery blisters,  
Inflammation about, or haemorrhage from, the navel.<sup>17</sup>

These Rules did not mention other less tangible aspects of postnatal care.

Midwives' responsibilities in the postnatal period include the educational, psychosocial and physical.<sup>18</sup> To fulfil educational responsibilities, from the 1930s the CMB included the teaching of mothercraft, infant care, and the principles of nutrition in the Part 2 syllabus. The need for midwives to teach 'the constructive hygiene of mothercraft' was

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<sup>17</sup> NBS, CMB Rules, 31 March, 1918, p 23.

<sup>18</sup> Murphy-Black, 'Care in the Community in the Postnatal Period', p 120.

one of the arguments for increasing the training time in 1939.<sup>19</sup> This aspect of midwifery developed until by the end of the CMB's existence, teaching parentcraft antenatally had become an important part of the midwife's role.

The importance of psychosocial and emotional aspects of postnatal care did not receive full acknowledgement until the later decades of the twentieth century.<sup>20</sup> The early editions of Margaret Myles' A Textbook for Midwives, discussed briefly the psychology of the puerperium. However it was only when Myles Textbook for Midwives was given a whole new look in its eleventh edition in 1989 that the authors gave the psychology of the puerperium prominence along with chapters on sociology related to midwifery and counselling skills in midwifery practice.<sup>21</sup>

During a postnatal visit the midwife's duty was to perform a full physical examination of mother and baby. Prevention of infection was of primary importance. Thus, as the mother was officially confined to bed for ten days (although as shown below this was a rule virtually impossible to keep), the midwife's duties included monitoring the temperature, pulse and respirations, bedbathing, performing vulval swabbings, abdominal palpation to check for uterine involution, examination of the lochia and perineal area, and examination of the legs for signs of swellings which might indicate the onset of deep venous thrombosis (DVT). In addition, the administration of an enema and assistance in putting the baby to the breast could be part of a postnatal visit. During the same visit, the midwife had to take the baby's temperature, perform a top-to-toe examination paying

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<sup>19</sup> NAS, CMB 1/5, CMB Minutes, 26 July, 1934, Vol 19, p 24; CMB Rules, 31 March, 1939, p 13.

<sup>20</sup> J Raphael-Leff, Psychological Processes of Childbearing, (London: Chapman and Hall, 1991), p ix, but see the whole book for insight into maternal and family psychology related to childbearing, and chapter 33 for postnatal psychological complications, pp 477-497; J Watson, A Complete Handbook of Midwifery for Midwives and Nurses, (The Scientific Press Limited: London), 1914, pp 319-320. Here, 1 ½ pages are given to puerperal insanity, mania and melancholia.



particular attention to the eyes and skin, bath and dress the baby, attend to the cord/umbilical area depending on the custom of the day, and make sure the baby was feeding and sleeping well. The midwife had to record all her observations and if there was a problem, she was required by the CMB Rules to send for medical aid. Midwives practising in hospital also performed and recorded these postnatal examinations and observations. This gives some idea of the amount of work involved in a full postnatal visit particularly when mothers were kept in bed for ten days. Midwives visited mothers twice daily for the first three days and daily thereafter.

As well as postnatal visits, midwives on the district were on call most of the time for mothers in labour. Mary McCaskill working in Glasgow in the late 1940s said, 'We were on...twenty-four hour call [for deliveries]...We would have anything between ... eight... to about fourteen, fifteen postnatal visits to do'.<sup>22</sup> By the 1960s LAs realised that to be out all night looking after a mother in labour followed by a day of postnatal visits and perhaps another mother in labour did not make for the best midwifery and they started to employ more part-time married midwives. Fay McLeod was one of them. She explained,

We were relieving the full time midwives. Say somebody had been up all night delivering, then you were sent there to do their calls while they caught up on their sleep. So you could be in Possilpark one day, and Easterhouse the next, Drumchapel the next and then Silverburn the next. You could be anywhere. All over Glasgow.<sup>23</sup>

Having part-time relief midwives presented a problem of lack of continuity of care for mothers which affected the midwife/mother relationship. Fay McLeod said, 'If you were

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<sup>21</sup> V R Bennett and L K Brown, *Myles Textbook for Midwives*, 11<sup>th</sup> ed., (London and Edinburgh: Churchill Livingstone, 1989).

<sup>22</sup> LR, 35 [27].

<sup>23</sup> LR, 38 [117].

in one place for the whole week it was heaven...you actually got to know the people.’<sup>24</sup>

However most of the time they could be anywhere and in every type of home,

from a [house] in Pollokshields to a wee single-end somewhere, where they didn’t have a basin to bath the baby. And in those days you had to bath every baby in every house. When the cord came off you would say, “You could just bath baby yourself tomorrow”.<sup>25</sup>

However Margaret McNally, at the same interview, argued that this was not always so, citing the mother’s apprehension as a reason. She said, ‘At the first bath you had to say, “now, I’ll supervise you the first bath,” because they were very frightened, you know’.<sup>26</sup>

Not every mother received full postnatal care which meant that the CMB Rules were not always kept. Ann Lamb remembered working (privately) as a midwife in Inverurie in the 1940s. She said, ‘I just stayed in the house for a week. That was after the birth for the postnatal care but there wasn’t really much postnatal care in my day – just a wee look’.<sup>27</sup> Care was also less defined when howdies were in charge. Occasionally in rural areas there was no midwife to give postnatal care. Doddie Davidson in 1940s Aberdeenshire said,

There wis nae midwife... I looked after the mother after the baby was born...I washed the Mam and saw that she wis [all right]...And the bairn too – I bathed the bairns. An then ye stayed, sometimes a wik sometimes mair, sometimes ye didna hae time ti spare but ye aye hid about a wik wi them or ten days.’<sup>28</sup>

Another howdie, Annie Kerr, also in the 1940s but at the other end of the country, said,

I took care of the baby afterwards until she wis fit. I wid mebbe be there a fortnight...When I was staying with the women having their babies, I did everything. The washing, cleaning, into Castle Douglas for the messages. The mother would see to herself – by that time she was fit. I took care of her when she was in bed. I didna let her work while I was there. That’s what I was there to dae.

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<sup>24</sup> *Ibid.*

<sup>25</sup> *Ibid.*

<sup>26</sup> LR, 39 [119].

<sup>27</sup> LR, 19 [47].

<sup>28</sup> LR, 26 [101].

I was there to work. And save her, till she gathered her own strength again. I gave her a basin to wash herself. I never took nowt tae dae wi the washin. I looked after the baby and everything for her and did aa the housework.<sup>29</sup>

Yet one howdie, Johann Robertson, working in Aberdeen in the early decades of the twentieth century, did things differently, even though still not conforming to CMB Rules.

According to her granddaughter,

Postnatally, she had a strict routine and according to my late mother, Grandma would clean up the patient first after expulsion of the afterbirth and immediately wrap her up in a supporting binder round the stomach to prevent sagging of the abdominal muscles. My mother felt the benefit of this in later years! The binders were usually made of flannelette sheets torn to the required strip for size. She also collected old sheets from neighbours and made the bandages herself. If the mother had insufficient milk she too was 'binded' to prevent drooping.<sup>30</sup>

One district midwife had a set routine immediately after a home birth in the 1960s. She said,

One of the joys I had was this lovely feeling of warmth and a lovely feeling from everyone. It used to be my great joy once we had got the baby and I used to wrap it up all nice and cosy and give everybody a wee quick look and then I'd have lovely warm sheets and a warm nightie and bath towels just ready – things for the mother and things for the baby and after everyone had seen the baby... I used to put some oil on it to get the vernix off and I used to wrap it up in warm towels and leave it there resting. Then I would bedbath the mother from top to bottom, give her her tooth-mug, into her clean sheets and warm nightie, offer her her cosmetic bag, get the hair brushed and then I used to say to usually the [grand]mother, 'I think your daughter would just love a cup of tea,' and she would go and do that and I would bath the baby, dress him in nice warm things, put him in a warm cot and then they were allowed to come in and I used to go away and go to the bathroom and do all the cleaning out, all the slungeing, getting rid of everything that had to be got rid of and assessing the afterbirth. I did that on my own to give them time together and I would leave that house and there wouldn't be a speck of blood anywhere. That was my great joy of home confinements. Probably I was lucky. I had a lot of lovely home confinements. Any difficulties that I had I would know when to call the doctor.<sup>31</sup>

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<sup>29</sup> LR, 28 [110]

<sup>30</sup> Written testimony, LR, [3].

<sup>31</sup> LR, 15 [9].

Occasionally a mother would not allow the midwife in to do postnatal care. In Glasgow, for instance, a pupil midwife could deliver the baby with a midwife and never see the mother again. Anne Bayne said, ‘often when the Green Lady went [to do a postnatal visit] she did not get in’.<sup>32</sup> Thus, the ideal of postnatal care as laid out by the CMB, was not always performed in the way the Board expected.

It was easier to keep to the Rules when mothers were in hospital and under a watchful eye. Ella Clelland went to her first midwifery post to the Vert Hospital, Haddington, in the 1950s and recalled,

We kept the mothers ten days and with a first baby sometimes fourteen. We had them in bed for five days and we swabbed them by douching them with Dettol water. We used to have a big trolley and all these jugs of Dettol douche water and pans underneath it and you went along and put them on the bedpan, and you had the douche and swabbing equipment, turned them on to their side examined their stitches and made sure that that was well healing.<sup>33</sup>

On the district, even though midwives worked on their own, the LSA checked that they obeyed the Rules. Mary McCaskill, practising in Glasgow in the late 1940s as a Green Lady, said, ‘You had to have your Rule book and that had to be produced at all times and of course we were subject to inspection [at home] of your uniform and your equipment – your bag’. She also described midwives working together to make sure their equipment was complete when they knew an inspection was pending.

And of course I’d be telling tales out of school – I had no disposable equipment. I had steel bowls and kidney dishes and gallipots, nail-scrubbers and... thermometer, stethoscope, but if you were short of something [and an inspection was pending], say I was supposed to have two gallipots and I only had one, I just phoned [another midwife] and said, ‘I’ll have a gallipot for tomorrow.’ And so [that was they way] it went. [They actually came] yes, very much in the image of the hospital matron.<sup>34</sup>

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<sup>32</sup> LR, 21 [91].

<sup>33</sup> LR, 15 [9].

<sup>34</sup> LR, 35 [27].

If a mother had a temperature of over 100 degrees Fahrenheit for over twenty-four hours, the midwife had to call for medical assistance. Subsequently, until 1980, the CMB Rules specified that the presence of an elevated temperature (degree not specified) maintained for over twenty-four hours, signifying possible infection, required the midwife to call for medical assistance and notify the LA.<sup>35</sup> Mary McCaskill recalled

If one of your postnatal mothers developed a [raised temperature]...[which] was maintained over...twenty-four hours...you were suspended from practice and a ...general...district nurse...who was a midwife [but] who wasn't doing midwifery took over the postnatal care and I would be suspended from practice. You see there was always this big danger in these years of puerperal fever. And this is why it could not be a midwife [so that infection would not be spread to other postnatal mothers]. I had to go home and wash my hair, have a bath and change my uniform. I had to have a throat swab taken to make sure I wasn't carrying the infection and then the supervisor would arrange a day and a time when she would come to the house and inspect all my equipment and see that I had a clean lining in my bag. You changed your bag [lining] every week of course. [Antibiotics were] in their infancy. It was sulphonamides then you know...M&B, the great 963 was it, 963, the first one...we gave mothers sulphonamides if they thought there was a rise in temperature. I would say they weren't used as widely as antibiotics are nowadays. They were new but they were used. They were considered a great boon to controlling infection. I hadn't worked as a midwife before the days of sulphonamides.<sup>36</sup>

CMB Rules for midwives to follow therefore emphasised the physical care of mother and baby. They were not always kept to the letter especially early in the century and where howdies were practising. Yet, even after the discovery of the first antibiotics, the CMB Rules regarding suspected infection and LA supervision of midwives on this issue were for many years clearly stated and, as shown above, strictly kept.

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<sup>35</sup> CMB Rules, 1968, p 13; CMB Rules 1980 Approval Instrument 1980, did not specify the raised temperature rule as hitherto. However it is implicit in rule 58, p 9.

<sup>36</sup> LR, 35 [27].

## Keeping the postnatal mother in bed

At the beginning of the twentieth century, medical practitioners, not unlike their nineteenth century predecessors, considered that a necessary lying-in period should be at least ten days.<sup>37</sup> Dr J K Watson wrote in 1914, 'The patient is to be kept in bed for at least ten days and in her bedroom for a fortnight'.<sup>38</sup> This was so that the mother could recover from the birth in a peaceful atmosphere with few visitors and establish breastfeeding. This midwifery textbook like others, demonstrated at least on paper, the authority that medical practitioners had over midwives.<sup>39</sup> In practice, this rule was difficult for a midwife to achieve and left a mother weak and often debilitated through lack of exercise.

Mima Sutherland, practising in Unst, Shetland in the 1930s and 1940s said,

After the birth I used to see them twice in the day. We were supposed to see them fourteen days. By the time they put their legs oot ower the side of the bed they would say, 'Look at my legs. What are they like?' They were wasted.<sup>40</sup>

Mothers often pretended to midwives that they had stayed in bed when in reality they had not. One midwife described how she always knew if the mother had been out of bed by the state of her feet.<sup>41</sup> Molly Muir, practising in Edinburgh in the 1930s recalled,

My district was Gorgie where I went every morning to bath my babies and deal with the mother, for about two weeks. Most of them had a neighbour who was very good to them. I remember one time calling at this house. I did the mother and bathed the baby and then I said, 'You know you've got on awfully well. I think you could get up this afternoon for an hour'. I carried on further up the street to another lady and she said, 'Hasn't Mrs. S. done well. She was up having tea with me yesterday afternoon.' You never knew what was happening when your back was turned. They weren't ill. She was pretending that she was doing all that she was supposed to be doing and that's what was going on.<sup>42</sup>

<sup>37</sup> J Towler and J Bramall, *Midwives in History and Society*, (London: Croom Helm, 1986), p 77.

<sup>38</sup> J Watson, *A Complete Handbook of Midwifery for Midwives and Nurses*, p 289.

<sup>39</sup> M Tew, *Safer Childbirth? A critical history of maternity care*, 2<sup>nd</sup> ed., London and Glasgow: Chapman and Hall, 1995), p 147; the *CMB Rules* said nothing about length of stay in bed.

<sup>40</sup> LR, 5 [56].

<sup>41</sup> Z Barnett, 'Yesterday, Today and Tomorrow in Postnatal Care', in *Midwives Chronicle*, November 1984, p 360.

<sup>42</sup> LR, 13 [46].

However, many mothers got up and got on with their work and did not try to hide it.

Betty Smith working in Glasgow in the 1940s said, 'The mothers weren't supposed to get up out of their beds till about the tenth day and you very often would go [to visit] and the mother had skipped out for messages'.<sup>43</sup> Midwives accepted the reality that most mothers could not stay in bed for the stated length of time because they had so much to do. Doddie Davidson said,

Keepin the mothers in bed depended on the mother a lot. Some o them wanted tae lie, some o them didna. But they were aye a few days in their bed. Sometimes about a wik. Sometimes if they hid ither little anes they wanted tae get up. But some Mams wanted tae lie. It aa dependit on them. Once they got up they were OK.<sup>44</sup>

May Norrie, practising in Froickheim and Carmyllie in Angus in 1947 was realistic too. She said, 'Oh well, I just left [them] to their own devices. But I knew perfectly well some of them were up and doing things for their family, you know'.<sup>45</sup> Margaret Foggie, pupil midwife in the depressed Glasgow of 1934 added another aspect to the postnatal period. She recalled,

The people... were very dispirited somehow. It was very sad. It was a very bad time... I never looked after anyone who had a husband working. You had to try and keep the mothers in bed but it was very difficult. You couldn't really insist on it. But you told the husbands – look after these children and remember [she] is not well... Run the messages for her and look after the weans. They would say, 'yes', but... I don't think they did. They used to stand around on the street, talking.<sup>46</sup>

Financial problems were echoed by Mary McCaskill who explained why in the late 1940s she sometimes had to negotiate times of visits .

We visited twice a day for the first four days [postnatally] and thereafter once a day up till the fourteenth day – I know that's been changed but that was what I did. [The mothers] sometimes weren't there. In some parts of Glasgow the mother

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<sup>43</sup> LR, 27 [93].

<sup>44</sup> LR, 26 [101].

<sup>45</sup> LR, 43 [70].

<sup>46</sup> LR, 22 [50].

was in receipt of dole money and they would hop off to sign on. That took precedence over everything else so, but usually you just had to work round it. Because you couldn't chain them to the bed... for seven days.<sup>47</sup>

However mothers who would not stay in bed probably did themselves a favour apart from avoiding wasting of the muscles as Mima Sutherland described above. A well-known hazard of staying in bed with no exercise was DVT. Annie Kerr recalled,

I wid mebbe be there a fortnight. It wis reckoned they shouldna be out o bed till the nine days were up. That wis quite a common thing. Ye had tae wait in yer bed intil a certain time and then get up but ye weren't allowed up because I remember one woman gettin up. The baby began to cry and I took no notice of it. I got on with the bakin, whatever I was doin in the kitchen and when I came in, here she was sittin wi the baby... She had got up... and walked across to the baby, and picked it up. I got sic a shock when I saw her. She was never any the worse of it. They say they liked to get ye up on yer feet. It saved clottin.<sup>48</sup>

Hospitalisation brought other hazards. In the 1950s with the number of hospital births rising, more mothers were in hospital for postnatal care for varying lengths of time with a normal of nine to ten days.<sup>49</sup> Cross-infection was more likely to happen in hospital than at home, highlighted by one district midwife working in the Outer Hebrides in the 1940s and 1950s who said, 'I don't remember any postnatal infections. You see they were in their own homes.'<sup>50</sup> Another hospital-related issue was episiotomy. More mothers had episiotomies in hospital than at home. With mothers still being kept in bed for about five days (and it was easier to enforce this rule in hospital than at home), an episiotomy nurtured in a warm moist atmosphere was an added potential source of infection. Jan Fenton working in the postnatal ward in Dundee Royal Infirmary in the mid-1950s observed that mothers with infected episiotomies were allowed up earlier than the usual day for a shower. She had what she thought was a good idea. She said,

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<sup>47</sup> LR, 35 [27].

<sup>48</sup> LR, 28 [110].

<sup>49</sup> Changing lengths of hospital postnatal stay and early discharge home are discussed below.



When they [the mothers] were in the wards they would be in for nine days. And ...they were kept in bed for five days... If episiotomies went 'off', they used to let them get up for a shower, you see. And I said to the sister, ' I think it would be much better if we just got them all up for a shower. It would save these episiotomies going off.' And I was told I wasn't paid to think.<sup>51</sup>

Midwives were expected to adhere to hospital policy regardless of changes which would benefit mothers.

Keeping mothers in bed for long periods of time eventually went out of fashion. Successive editions of Margaret Myles' Textbooks for Midwives demonstrated an unstoppable movement. In the first four editions Myles recommended that 'normal patients' are allowed out of bed

on the second day of the puerperium... for [no] longer than three minutes at first, and... encouraged to walk round the bed rather than sit on a chair. The time is gradually increased until the third or fourth day, when she is permitted to go to the 'toilet' and to have a bath-tub.

Myles cited the advantages of the above early ambulation which included: better drainage from, and rapid involution of, the uterus; fewer respiratory complications; reduction in thrombotic conditions; more rapid resumption of bowel and bladder function; and stronger, happier mothers with greater experience of handling their babies. Disadvantages included the possibility that once a mother was out of bed she would do too much. This would lead to poor establishment of lactation, fatigue and poor recuperation from giving birth, physically and emotionally.<sup>52</sup>

In her sixth edition in 1968, Myles said 'Normal patients are allowed to be out of bed on the first day of the puerperium; they may have a shower (with mobile hand spray) six hours after delivery'. However vulval swabbing by midwives at this time was still *de*

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<sup>50</sup> LR, 23 [99].

<sup>51</sup> LR, 40 [116].

<sup>52</sup> M Myles, A Textbook for Midwives, 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup> and 4<sup>th</sup> eds, (Edinburgh and London: E & S Livingstone Ltd., 1955 (reprint), 1956, 1958 and 1962), pp 453, 449, 449 and 474.

*rigueur*.<sup>53</sup> Myles made the same comments in her seventh edition in 1971 with the addition of comments on self-vulval swabbing and the use of bidets (with lucid instruction from the midwife and unremitting supervision). However, as the practice of early ambulation was now established and seemed to have no ill-effects, she stated, possibly to reassure wary midwives (or those who were not allowed to think), ‘ the practice appears to have no deleterious effect. Primitive women get up early with no harmful effects’.<sup>54</sup> By Myles’ eighth edition, published in 1975, early ambulation and self-vulval swabbing were accepted facets of postnatal care.

By 1961 the home birth rate in Scotland was down to 25 per cent with a further decrease to 15.4 per cent by 1965. There remained a shortage of maternity beds which was exacerbated by the increase in hospital births and the rising birth rate. Corresponding changes in postnatal care developed, with early ambulation and self-care of mothers, and the use of aseptic techniques and antibiotics where necessary. Increasingly, mothers were encouraged to tend to their babies themselves. The role of the midwife in the postnatal wards changed from one who performed full physical care for mother and baby to one who taught mothers to look after themselves and their babies with support and help where necessary.<sup>55</sup> The issue of hospital bed numbers combined with more able and mobile mothers pointed to the next phase: early discharge home.

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<sup>53</sup> M Myles, A Textbook for Midwives, 6<sup>th</sup> ed, (Edinburgh and London: E &S Livingstone Ltd., 1968), p 457.

<sup>54</sup> M Myles, A Textbook for Midwives, 7<sup>th</sup> ed, (Edinburgh and London: Churchill Livingstone, 1971), p 460.

<sup>55</sup> Murphy-Black, Care in the community in the postnatal period, p 124.

## Early discharge home

The ten day postnatal hospital stay gradually decreased to a mean of 5.3 days in 1980.

While this suited some mothers, with a few leaving hospital as early as forty-eight hours after delivery, the real reason behind the move towards early discharge home was the rise in numbers of hospital deliveries which put pressure on the existing numbers of hospital beds. There was also a corresponding need for antenatal beds which exacerbated the shortage of institutional maternity beds.<sup>56</sup>

The trend for early discharge linked to the shortage of hospital maternity beds is evident in the official reports from 1959. The 1959 Montgomery Report commented that a ten day period of stay in hospital after delivery was widely regarded as suitable although seven or eight days 'or even less' was quite common. However, when mothers were discharged home at ten days it was difficult to obtain enough midwives to fulfil the current fourteen days statutory postnatal visiting requirement. It became even more difficult when mothers were discharged earlier and there was little consensus. The RCM argued that mothers who were discharged before ten days were not so happy or confident and had difficulty establishing breastfeeding. In contrast, the Scottish Standing Committee of the RCOG opined that with the current shortage of beds 'more admissions and shorter stay' might be preferable; similarly the British Paediatric Association suggested a pilot very early discharge from hospital scheme, even though they acknowledged that this did not help breastfeeding.<sup>57</sup>

Fourteen years later the Tennent Committee reported on integration in the maternity services. While acknowledging the convenience of early discharge for some

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<sup>56</sup> *Ibid*, p 123; Myles, *Textbook for Midwives*, 6<sup>th</sup> ed, p 460, and 7<sup>th</sup> ed, p 463.

<sup>57</sup> *Montgomery Report*, 1959, p 17.

mothers, the Report stated that this should not be universal and opposed using early discharge solely as a method of increasing bed turnover. Nevertheless the Report admitted this might happen ‘as a temporary expedient in order to provide specialist services for a greater number of patients’.<sup>58</sup>

The views of midwives and women about the length of stay in hospital were mixed. Betty Smith, midwife, thought that for some women a longer stay in hospital was a good thing. She said,

[With early discharge] I feel the mothers are getting put out too quickly. When they were in hospital, particularly mothers that had family, after their babies were born they could have the sleep because the nurses (sic) were there to look after the babies at night. They were having their food brought to them, having their baths – many a patient didn’t have a bath to go home to. They were able to have their baths and a rest... Yes they had an afternoon nap... lying on their tummy. With a pillow maybe under their tummy... they got wakened after that [for tea]. If they get sent home... they don’t get that rest... Now some of the patients wanted home but that was up to them. They would request a forty-eight hour confinement. I just feel now they’re – because the postnatal blues at about the third and fourth day – that’s when they want to cry. They want all the assistance they can get and their bosoms [are sore] or – you know.<sup>59</sup>

Fay McLeod agreed that in the 1960s before the trend was established, early discharge was sometimes by maternal request. She said,

Sometimes it was within twenty-four hours if they pressed hard enough to get out. I’ve gone to visit somebody the morning after they’ve got home and they’ve been away out somewhere and it’s only less than forty-eight hours since the baby was born. Thankfully not too many of them were as silly as that but you did get the odd one.<sup>60</sup>

Gelda Pryde moved from Fife to Angus in the 1970s. She commented on extremes of postnatal care related to early discharge she had encountered.

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<sup>58</sup> Tennent Report, 1973, p 14. The Tennent Committee’s attitude to 100 per cent hospital deliveries is discussed in Chapter 7, p 240.

<sup>59</sup> LR, 27 [93].

<sup>60</sup> LR, 38 [117].

The whole type of care [changed]. After delivery they were in bed for ten days, swabbed twice a day, three times a day until the tenth day. [Then] when the early discharge came in so many of them [mothers] thought, Oh this is great, but when you went to do their home visit two days later they're... all stressed out and saying, 'Oh I wish I'd listened to you and stayed in hospital for a few days longer'... Quite often, yes, when you would visit them days later, they would wish that they had not been in such a hurry to get home.<sup>61</sup>

She also agreed that the planned early discharge scheme arose mainly because of the shortage of beds brought about by the push for hospital births. This comment fulfilled the forecast made in the Tennent Report and the recommendation for 'more admissions and shorter stay' made in the Montgomery Report.<sup>62</sup> She said,

I can remember this Planned Early Discharge scheme. That was, I think more governed by the need for beds rather than looking at what the patients' wishes were. It must have been at Forth Park [in the late 1960s] because we were never short of beds in Angus, but I think... it was so that we could do more deliveries in hospital and to get everybody in for delivery then they had to have this planned early discharge, so if they had a normal delivery and everything was fine, they could go home. It was forty eight hours when it first came in. It was [official policy]... If it was a first baby they were usually persuaded to stay in or if... it was an unsuitable home for whatever reason, you know their facilities weren't good or there were lots of other children or people sharing their homes or whatever, they were usually kept in. So it was normally uncomplicated para ones, twos.<sup>63</sup>

Although early discharge home developed from the need for maternity beds, it was still strictly controlled.<sup>64</sup> If a mother indicated antenatally that she would like to go home from hospital early, it became policy for the community midwife to inspect the home for suitability. Myles' textbooks gave didactic instructions for how midwives and GPs should negotiate this with a mother. For example, 'an initial visit is paid by the midwife to assess the home conditions and discuss domestic conditions. Overcrowding is not acceptable'. Myles discussed issues such as adequate heating and 'the help of a

<sup>61</sup> LR, 42 [69].

<sup>62</sup> See references 57 and 58.

<sup>63</sup> LR, 42 [69].

<sup>64</sup> Myles, *Textbook for Midwives* 6<sup>th</sup> ed, p 460.

reliable woman', before saying 'about the 36<sup>th</sup> week an evening visit is paid [by a midwife] to confirm that arrangements have been completed and to gain the husband's co-operation'.<sup>65</sup> These instructions contrast with the situation as late as the 1950s when midwives delivered women in one-roomed over-crowded homes without necessarily being assessed for suitability and the Montgomery report was trying to promote home births.<sup>66</sup>

Transfer not only occurred from hospital to home, but also from hospital to hospital. A mother could be sent to a large specialist maternity unit for the birth, because of problems arising ante, or intranatally, and returned to a smaller local unit for postnatal care. Maureen Hamilton trained in Glasgow and practised as a midwife, beginning in 1970 in the small hospital in her home town of Campbeltown. She commented,

That was very different [from working in Glasgow] because we dealt with the Air Ambulance from Campbeltown to Glasgow if there were any complications... Often the GPs panicked a bit... [even] when they were cracking on quite well in labour. They sometimes just didn't really give them [the mothers] a chance. They would say 'Oh I think there are going to be problems. We'll need to get her to Glasgow.' Then she would deliver as soon as she arrived [in Glasgow] which wasn't fair on the patients... [When the mother and baby returned] we had them postnatally... They kept them in the hospital for about seven days then and it was lovely because it was a home from home for them, overlooking the loch. The mothers who came in there loved it.<sup>67</sup>

Ella Clelland was another midwife who spoke about mothers who gave birth in one hospital and transferred to another for postnatal care. She said,

I went to the Vert Memorial Hospital [in 1958] just outside Haddington. I was there for about two years as a staff midwife. That was very good. It was GP run. They had no doctors within the hospital but there were something like thirty-odd GP s within the East Lothian area. Some of them were very old and had been there for quite a long time. Some were quite young with quite new ideas...

<sup>65</sup> *Myles Textbook for Midwives*, 8<sup>th</sup> ed., p 410.

<sup>66</sup> See LR 21 [91], this chapter, p 287; *Montgomery Report*, p 40.

<sup>67</sup> LR, 30 [112].

We did not do complicated midwifery. Anything complicated was taken into Edinburgh to the Simpson or the Eastern, so we as midwives would know when we needed help. But in the main it was normal midwifery with occasionally a breech delivery or low forceps - no ventouse then – and we called the GP when we felt we had difficulty... Work at the Vert was pretty good experience of the normal side of life and anything that was too abnormal required to be shipped off to Edinburgh and we went in the ambulance with them and took them to hospital there and then all being well we had them for the postnatal period which was ten days. We kept the mothers ten days and with a first baby sometimes fourteen.<sup>68</sup>

Gelda Pryde who became Senior Nursing Officer in Angus in 1973 described postnatal care given in a small general hospital in Angus.

The Fyfe Jamieson Hospital [in Forfar] closed and we got a ward in Whitehills which was one of the long-stay units and we did DOMINO deliveries there with the possibility of the mothers staying in for up to twenty-four, forty-eight hours if necessary with the community midwives going in visiting them. The care being by general nurses but the community midwives going in as they would have visited them at home. They visited them in hospital. They really needed minimal care but it was to have somewhere as an alternative to home for babies with feeding problems where they were getting some support and where home conditions weren't really suitable for the mum to go straight home. This was a sort of respite care almost if you like. The Scottish Office were very interested when we started it.<sup>69</sup>

### Contrasts in midwifery practice

High on the agenda of most midwives who I interviewed was the poverty they encountered both as pupil midwives and as midwives. This was something which most of them had not previously met. Anne Chapman worked in the dunnies in Glasgow.<sup>70</sup> She said, 'My mother wouldn't believe me when I was telling her that. She would say, "ye're bletherin lassie"'.<sup>71</sup> Margaret Dearnley trained in Lennox Castle in 1946 which involved

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<sup>68</sup> LR, 15 [9].

<sup>69</sup> LR, 42 [69].

<sup>70</sup> The dunnies are discussed in chapter 7, p 248.

<sup>71</sup> LR, 2 [11].

being on the district in some areas of Glasgow. This left her with some unforgettable memories. She recalled

Now, the poverty was dreadful. Very very bad. I remember going in a house which was all dark, but a great big roaring fire. And there were two or three kids running about you know with wee vests on and nothing else and a packed earth floor. And the new mother... was lying on what they call ticking. Now you know the ticking is the bed ticking. She was lying on ticking on a bed, an iron bedstead in a corner. And then the other corner of the room was all the orange boxes with the fruit and everything and her husband was a barrow boy. And these kids played about in there and that was where they lived and that's where he stored his fruit.<sup>72</sup>

Margaret Dearnley also recalled seeing huge contrasts in homes sometimes within a single day's work. She also highlighted how it was normal procedure for midwives to carry with them tokens supplied by the council to use in gas meters. She remembered particularly one wet Sunday morning .

Another house I went into... had two apartments... a kitchen with a bed recess and ... what they called their front room... and [an] outside... closet... [It was] a day of torrential rain. I went in to bath the new baby to find the woman... lying there and no fire, nothing, and I said, 'Have you had a cup of tea?' She said, 'No'. And I said to her, 'What's wrong? Why has nobody been in? Where's your husband?' 'Oh, he left when he knew the baby was coming. He left me. He left me three weeks ago and I haven't any money' ... I went to the lady next door... [which] we'd been instructed to do... She said to me, 'I'm sorry, I can't give you any money. I've given her money before and he's stolen it. He's even tampered with the meter, for the drink' ... I said, 'Well she's lying there and... she's got the baby in beside her for warmth. It's never been washed... She hasn't had a cup of tea; the house is freezing cold. There's nobody there even to light a fire.' So she said, 'Well I'm sorry, I can't do any more.' And shut the door. So I went back to her... and I... [used] tokens given by the Parish for the gas meter... and [lit] the gas heater... boiled the kettle... got her a cup of tea and washed [the baby], got her washed... and I think I lit the fire... I took my uniform off... because I was frightened it would get dirty and it was wet with the rain anyway... So I left her and went to the next close, two or three doors up. The same kind of house and to be met with the granny of the new baby and the great-granny... all smiling. They said, 'Oh how nice nurse', and she says, 'I hope you don't mind but... we just left the baby for you [because] we thought that perhaps you would like to dress the baby for its first outing... to the church.' They were Catholic people. I said, 'That would be nice to do that.' They took my wet clothes from me... into the other room and I was in the front room [with] the new baby and the

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<sup>72</sup> LR, 1 [20].



mother. After I examined [them both] and dressed the baby [in its special clothes] they brought in tea and they had dried my skirts to the best of their ability... They gave me an old umbrella for the worst of the rain... So... the two contrasts in the same style of house... on the one Sunday morning in Glasgow. [One with]... not even the money to put in the gas and [the other], the warmth and happiness and pleasure and everything so nice.<sup>73</sup>

Agnes Morrison also told of contrasts in mid-1940s Leith Walk.

I remember going into one tenement and strangely enough I had delivered two babies within about forty eight hours of [each other] in the same tenement... [In this family] I think it was about her eighth baby which was being born... and the father had taken time off to be there at home and you know they hadn't all that much and the baby was welcomed; it was just lovely... Two rooms maybe and a kitchen and the little girls in the house were helping. It was just such a happy family... One stair up from there, a first baby being born, it was an immediate atmosphere as soon as you went in, everything immaculate... The baby was eventually born. I asked where the husband was and there wasn't much [letting on]. He came in pretty fou and he had the most terrible scars... His wife had just taken her two hands down his cheeks before he'd gone out. Those awful scratches. Whereas ... those others were so happy [but] hadn't much.<sup>74</sup>

Anne Bayne also encountered extreme poverty in Glasgow in the 1950s. She described a very poor one-roomed home.

We had to do case studies for our Blue Book and [this was one].<sup>75</sup> I think this woman was para ten [eleventh pregnancy]. She had this one room. She was thrilled because they had actually the sink – the jaw-box in the window. There was a fireplace with a mantelpiece and it was an little open fire, a range, where she did all her cooking. That night the older boy and the father went through into the next room. There was a box bed [with] a sheet over [it] and... five children of varying ages in behind that sheet and... five little peep-holes in the sheet... She had her bed and at the end there was a heap of coal and... a cot and... two in the cot... and Moses basket... at the other side... There was another bath there [with] the last baby... in it and now we were delivering the new one. There wasn't room for the doctor and the midwife and myself to stand on that floor. We took it in turns to sit on the bed. There was a wee paraffin lamp which was all the light we had and we took turns to hold that depending on who was doing what. We had a plate, a soup plate and we had a Higginson's syringe and so we gave the enema out of this plate; she returned it into the plate. I handed it out of the door and I don't know where it went, and the plate came back. I took the placenta into that plate and I bathed the baby in that plate. We would have been finished and away

<sup>73</sup> *Ibid.*

<sup>74</sup> LR, 31[35].

<sup>75</sup> For further discussion on the Blue Books see chapter 6, p 200.

about four o'clock in the morning and the Green Lady said, 'Now everything is done. I'll go and phone for your taxi'. By the time the taxi came and I went down, the mother had told me about how the midwife had been murdered on the stairs.<sup>76</sup> In the case of this mother who would have benefited from postnatal care and support, Anne Bayne said, 'They went again at ten o'clock to visit her and never got in. Nobody ever got back to see her postnatally. She didn't open the door.'<sup>77</sup>

Some midwives chose to practise in homes which were materially better-off. Most midwives spoke about the poverty they saw either during midwifery training or practice, yet there were some who practised as private midwives amongst better-off mothers. These mothers could afford to pay a midwife to attend the birth of the baby, with or without the GP, and live in the house for some time postnatally. One of these was Ann Lamb who trained as a midwife in a small training school in Edinburgh in 1927 as a route to nursing. She joined a nursing association based at the Armstrong Nursing Home in Aberdeen enabling her to practise privately both as a nurse and midwife in many parts of Scotland.

I went from place to place to deliver [babies]. But I delivered them in hospital too in Edinburgh and Aberdeen in the Armstrong Nursing Home, now St. John's. I have been in Grantown-on-Spey at the hospital... away down at Montrose, at Carnoustie, in Kirkcaldy. I don't think there is a town I haven't been in, but not the west coast, Oban and there.<sup>78</sup>

Ann Lamb usually stayed about a month postnatally with mothers. However, she did not call herself a 'monthly nurse'. This old term dating from at least the 1500s applied to a woman (not a midwife) 'who in a substantial family would be engaged to perform the more menial tasks during the birth, and to nurse the mother and infant for the following

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<sup>76</sup> LR, 21 [91].

<sup>77</sup> *Ibid.*

<sup>78</sup> LR, 19 [47].

month'.<sup>79</sup> Later, in the eighteenth century, medical practitioners encouraged monthly nurses as allies in an effort to consolidate their practice against midwives.<sup>80</sup>

Molly Muir was another midwife who worked privately in the 1930s after training at the 'old Simpson' in 1934. She used the term 'monthly nurse' to describe what she did.<sup>81</sup> She said,

When I finished [midwifery training] I went to private nursing. In these days if you were a sister in a hospital or anywhere, the salary was eighty pounds a year whether you had been there two years or twenty years. In private nursing, if it was a baby case it was four guineas a week. Of course if you weren't working you weren't paid. But I did a whole year of baby cases with no day off because the cases ran into each other. I was acting as a monthly nurse and you would probably go to the case a week before labour started. That put you all wrong for your next case. It was very hard work but I loved it. I loved looking after those babies. I did the postnatal care of the mothers as well. I used to go to places like Saline and down to North Berwick and Berwick-on-Tweed – wherever they wanted a midwife. We had our headquarters in Rutland Street – Miss Drummond was our matron and there were about eighty trained nurses and midwives on the staff and they went out to different cases.<sup>82</sup>

Katie Strang also worked privately after she completed two years' midwifery training at Rottenrow in 1952. She was one of the few midwives by this time who was not a general trained nurse. She decided she would work privately and to begin with she obtained work through her local GP.

So he thought I should do private maternity and he got me my first patient. And he said, 'It's quite an easy one because she's a marvellous mother, she breastfeeds and...it's her fourth baby'... He said, 'She knows far more about it than you will'... So all was well and he came and delivered the baby and everything was fine, in June... That was my first and from then on it became a snowball thing... I never advertised, ever. She passed the word on to somebody who was having a baby and so it went on.<sup>83</sup>

<sup>79</sup> J Donnison, *Midwives and Medical Men*, (New Barnet: Historical Publications, 1988), p 23.

<sup>80</sup> *Ibid*, p 40.

<sup>81</sup> The issue of midwives and maternity nurses/monthly nurses is discussed in chapter 4, p 112. 'Monthly nurses' in the twentieth century were usually employed privately. The monthly nurse usually worked with a GP.

<sup>82</sup> LR, 13 [46].

<sup>83</sup> LR, 24 [89].

Mothers booked Katie Strang for the birth and postnatal care to begin with. However with the change in place of birth that began to change too.

[I was booked for the birth] and...when I started off [in 1952] it was usually for four weeks, depending what the mother wanted or how many other children she had. It gradually got less and less [home births] and by 1966 they stopped having them at home.<sup>84</sup>

She also said even when she was employed for the postnatal period only, she did not do much postnatal care. Here she raised a point about visits by other professionals which indicated that even though she, a midwife, was there, the district midwife still visited postnatally.

I was really employed for the baby. [I didn't give] very much [postnatal care] because you see they had this nurse [midwife] coming in and then the health visitor...I used to try and get them to do their exercises...A lot of them weren't keen. I didn't do a great deal really. I had to help them of course with breastfeeding and engorged breasts and things.<sup>85</sup>

Within their own small worlds private midwives wielded a certain power, protecting the mother from the outside. Katie Strang said,

I always insisted on the mother having a sleep in the afternoon after the two o'clock feed. If anybody came to the door between three o'clock and four, I would say, 'well I'm terribly sorry but she is sleeping.' Some of them were quite annoyed. I was considered quite a bit of a dragon I think.<sup>86</sup>

One man in his sixties agreed with this. He remembered Ann Lamb in the house looking after his mother and baby brother when he was boy of seven and said, 'I couldn't stand her. She wouldn't let me in to see Mum.'<sup>87</sup>

Midwives therefore worked with a wide range of people from all backgrounds.

Some chose to work privately, thus shielding themselves from extremes of poverty which

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<sup>84</sup> *Ibid.*

<sup>85</sup> *Ibid.*

<sup>86</sup> *Ibid.*

<sup>87</sup> *Personal communication*, LR, [127].

they had probably met during their training. Some, like David Rorie's 'The Howdie', went everywhere:

A' gate she'd traivelled day an nicht,  
A' kin o orra weather  
Had seen her trampin on the road,  
Or trailin through the heather.<sup>88</sup>

Gelda Pryde put it in a nutshell when she said, 'You know, you were talking about bare floorboards one minute and then two inch thick pile carpets two hours later'.<sup>89</sup>

## Conclusion

This chapter has explored some facets of the work of midwives postnatally between 1916 and 1983. This work was regulated by the CMB and supervised by the LSAs on the Board's behalf and midwives were required to keep within these Rules. Other rules such as the length of time a mother was supposed to remain in bed after giving birth were also present although not imposed by statute or the CMB, but by the views of the medical profession. This rule changed informally over the years as midwives found that especially at home, most mothers, particularly those who were very poor, had no help in the home and who had many children, left their beds to get on what they felt they had to do.

Although the basic rules for postnatal examination of the mother and baby remained the same during this time, the pattern and organisation of postnatal care changed. CMB Rules for the length of time midwives attended on postnatal mothers and babies changed from ten to fourteen days in 1939 and back to ten in 1965. The increase put pressure on domiciliary midwives and the move back to ten days helped to alleviate

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<sup>88</sup> D Rorie, 'The Howdie', in D Rorie, *The Lum Hat Wantin the Croon*, (Edinburgh: W & R Chambers Ltd., 1935), p 64.

<sup>89</sup> LR, 42 [69].

this, especially alongside the trend in the 1960s towards early discharge and many postnatal home visits.

The emergence of early discharge home schemes therefore aided the hitherto threatened role of community midwives although they were restricted mainly to postnatal care. Nevertheless, although postnatal care of mother and baby is an important part of midwifery, midwives performing only postnatal care were not fulfilling their full role as midwives. In addition, the restriction of the community midwife's role to postnatal care led to fragmentation of care for the mother. In the early decades of the twentieth century with most births taking place at home, continuity of care intra and postnatally, was taken for granted. The move towards hospitalisation and the tripartite administration of the NHS combined to break up care of women during the child-bearing episode. Early discharge home added another facet of fragmentation: mothers delivered in hospital by a midwife they did not know, spent one to three days in a postnatal ward looked after by numerous midwives, and then went home to be visited by more midwives they often had not met. In addition, while early discharge home might have returned individual care of women to midwives, for a long time there were not enough community midwives in many places to give adequate care at home. Many of the issues of fragmentation of care and midwives not fulfilling their full role were addressed in Scotland in the later decades of the twentieth century by schemes such as the DOMINO scheme and integration of maternity services.<sup>90</sup>

Midwives giving postnatal care at home in Scotland throughout the period exercised their autonomy and made their own decisions as they worked with mothers in

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<sup>90</sup> DOMINO is discussed in chapter 7 p 242 and integration of maternity services is discussed in chapter 5 p 157.

the domestic setting. Most midwives I interviewed took a realistic attitude to mothers getting out of bed before the allotted day and noted that they could not chain the mother to the bed. When more births took place in hospital, hospital policies reduced midwives' ability to give individual care to mothers in the postnatal period. Recent research of postnatal care in Scotland indicates that with hospitalisation came an increase in medical control of postnatal care despite the fact that this came within the midwife's area of responsibility.<sup>91</sup> Jan Fenton confirmed this attitude in the incident when she suggested that mothers with an episiotomy should get up for a shower instead of waiting for the designated day.<sup>92</sup> The response was that she was not paid to think.

The CMB undermined midwives' autonomy in 1965 when it agreed to an amendment of the NHS (Scotland) Act allowing nurses and health visitors to give care to mothers and babies within the postnatal period. This removed at a stroke midwives' special place in the field of postnatal care. It took eight years and a change in three-quarters of its members for a later CMB to realise that they had given away a large part of midwives' *raison d'être*.<sup>93</sup> This only began to be regained with the gradual implementation of the integration of maternity services in Scotland in the 1970s and 1980s.

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<sup>91</sup> Murphy-Black, 'Care in the community in the postnatal period', p 124.

<sup>92</sup> See this chapter p, 280.

<sup>93</sup> See above p 269 and footnote 12.

## Conclusion

The aim of this project was to initiate research into the history of midwives in Scotland in the twentieth century. A review of relevant literature revealed that there has been little written about the history of Scottish midwifery, although the history of midwives and midwifery practice elsewhere has received a significant amount of attention.

Furthermore, there has been a tendency to include the history of Scottish midwifery within the all-encompassing appellation of 'British' without acknowledgement of the differences in twentieth century legislation, training and practice which existed between England and Wales, and Scotland. Also, the 1915 Midwives (Scotland) Act, while necessary as a regulating instrument, served at the same time to curtail the autonomous and decision-making activities of midwives. Finally, midwifery practice was bound by opinions of those in other professions and results of events beyond their control. Thus, the essential purpose of this thesis became clear: to explore the ways in which different agencies came together to affect the autonomous practice of midwives in Scotland between 1916 and 1983 when the CMB oversaw their training and practice.

Because of the importance of the CMB, this thesis initially focussed on its work. Firstly it demonstrated how the CMB, a body with statutory powers conferred by the 1915 Midwives (Scotland) Act, regulated midwifery practice in Scotland from 1916 to 1983 through a system of Rules, training and examinations, and supervision of practice. Secondly, using a series of interviews from midwives undertaken in Scotland between 1997 and 2002, the thesis examined the lives and work of midwives practising during the period of the CMB's existence. The two differing aspects of research: archival and oral history, have served to illuminate contrasts between a perceived ideal of the Rules of the



CMB and the real world of hands-on midwifery practice. They also raise questions for future research.

### **The Central Midwives Board**

Research into the CMB, its work, progress, character and development formed the framework for the first part of the thesis. Ann Oakley's work on antenatal care in The Captured Womb spans a similar period to that of the CMB.<sup>1</sup> She argues that a major factor in the decline of midwives in the care of women undergoing a normal childbearing episode was the increasing recruitment of midwives from the nursing profession.<sup>2</sup>

Although her sympathy for midwives and midwifery is evident, her main concern is with the history of the medical care of child-bearing women and thus her account of the history of midwives is limited. This thesis adds to the story: it investigates regulation which for the first time involved midwives. The CMB at its outset in 1916 included two statutory midwives. Although this was a long way from self-regulation, it was a start. By 1983, its statutory quota of midwives was seven, but, in reality, there were ten midwives on the Board of sixteen. Thus within this period on the Board, midwives, better educated and more confident, developed a greater presence.

As midwives' education improved and their confidence increased, the idea of their achieving parity with doctors within the maternity care team slowly became more realistic although still not attained by the end of the CMB's existence in 1983. The CMB, a product of the implementation of the 1915 Midwives (Scotland) Act, was the essential body for the oversight of midwifery in Scotland. But the CMB, until the 1970s, perpetuated the hierarchical customs of the day. Thus, when opportunities arose for the

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<sup>1</sup> A Oakley, The Captured Womb, (Oxford: Basil Blackwell Ltd, 1984).

Board to make comments, for instance to the Montgomery and Tennent Committees, while it lamented the lack of a career structure for midwives, the Board's statements kept midwives firmly in a role subordinate to GPs and obstetricians. Throughout most of its existence the CMB reduced the autonomous practice of midwives and its influence prevented them from achieving parity with those with whom they worked.

In what ways was the CMB reluctant to allow midwives to practise autonomously? First, the Board was unwilling to allow midwives to perform antenatal care; nor did it allow midwives to give mothers inhalational analgesia in the 1930s and early 1940s by which time the CMB (E&W) had agreed this extension of midwifery practice; the Board controlled midwifery practice through close supervision of midwives, to the extent that even midwives' bags were inspected; it agreed to the application of strictly observed hospital policies which prevented midwives from using their initiative. Given that the 1915 Midwives (Scotland) Act and subsequent relevant Acts approved autonomous practice of midwives in normal midwifery,<sup>3</sup> the CMB's attitude was patronising and probably prevented many midwives from achieving their full potential.

Parity between the CMB and its counterpart, the CMB (E&W), was also a problem for midwives in Scotland. During inter-Board discussions the Board attempted to maintain its own independence and identity. This at times proved difficult. On numerous occasions, the more experienced CMB (E&W) while giving lip-service to the concept of working together, tended to make unilateral decisions and inform the Scottish Board afterwards. This was a source of much irritation, but even when the CMB (E&W) agreed to consult, it was usually the Scottish Board which gave in for the sake of

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<sup>2</sup> See Introduction, p 8.

<sup>3</sup> See Introduction, pp 1 and 2.

reciprocity. This was particularly evident in discussions over changing the length and format of midwifery training. In the 1920s, 1930s and again in the 1970s when discussions about Midwifery Directives of the EEC were on-going, the CMB argued strenuously with the CMB (E&W) against extending the midwifery course. This was on the grounds that it was not necessary, it was an expensive change and, in the 1920s and 1930s, the time was not right. Each time the CMB acquiesced and finally agreed to extend the course. Why the Board was so unwilling to do so is a question that deserves future research.

Despite the Board's reluctance, midwifery training and education expanded both in content and duration between 1916 and 1983. Initially, training according to the Rules of the Board was laid down to the last minute detail. With its fifth major revision of the Rules in 1947 the Board made apparent a change in thinking: minutiae were replaced by general principles. While the Board hoped that the new Rules would appeal to intelligent well-educated young women and help in the drive to recruit midwives, the eradication of closely prescribed instruction also indicated a progressive step from 'training' to 'education'. However this was countered by the fragmentation and medicalisation of maternity care after the implementation of the NHS (Scotland) Act in 1948.

The main reason behind the course changes in the 1920s and 1930s was the cross-UK concern about the unacceptable levels of MMR. However, although the whole midwifery course received modification particularly in the late 1930s, the CMB's main attention was focussed on first commencing, and then increasing, the antenatal care component of the course. The CMBs across the UK assumed poor antenatal care was a large part of the maternal mortality problem. But this contrasts with Loudon's

conclusions based on comparisons of the trends in maternal mortality in various countries. He showed the connection between lower levels of MMR and good midwifery education and practice together with respect for midwives. Loudon, in contrast to the CMB, made the importance of midwives' role in lowering the MMR by their attendance at births very clear.<sup>4</sup>

Although the CMB appeared reluctant to make alterations which would change the length and format of the midwifery course, there was one major unilateral modification which the Board made in 1968: to stop direct entry midwifery training in Scotland. At the same time the CMB started a one-year single part midwifery course and the eradication of direct entry midwifery in Scotland passed with little comment. This move was not surprising. As far back as 1929, Dr James Young, an Edinburgh obstetrician, voiced the hope that nurse-trained midwives would be produced in such large numbers that there would soon be little or no room to take the untrained.<sup>5</sup> Although the CMB appeared to agree with the 1949 Report of the Working Party on midwives in their support for the direct entry midwife, in the CMB Rule book for 1947 it excluded from teaching, any midwife (whether MTD or not) who was not also a registered nurse.<sup>6</sup> And, in 1953 Professor Johnstone was pleased to comment on 'the noticeable drop in untrained women'.<sup>7</sup> The Board was also against the EEC Midwifery Directives' stipulating a direct entry midwifery course. Although it finally had to acquiesce with the Directives which came into effect in January 1983, it was to be nearly another ten years

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<sup>4</sup> I Loudon, *Death in Childbirth*, (Oxford: Clarendon Press, 1992), Chapter 24, 'European Midwives', pp 402-427; see also chapter 3, p 84; and Introduction, p 11.

<sup>5</sup> J, Young, 'A Scheme of Maternity Service Co-ordinating Antenatal Treatment, Domiciliary and Hospital Treatment', *The Transactions of the Edinburgh Obstetrical Society*, Session LXXXVIII, 1928-1929, pp 95-107. (Reproduced in *Edinburgh Medical Journal*, New Series, Vol. XXXVI., No. 6, June 1929); see chapter 3, p 104.

<sup>6</sup> *CMB Rules*, 1947, Rules B 28, p 22.

before the first three-year midwifery courses appeared in Scotland for men and women who were not nurses. Given that other European countries including England and Wales appeared to agree with the concept of a direct entry course as an acceptable form of midwifery education, the question remains for future research: why was the CMB for Scotland so against non-nurses becoming midwives?

### **Midwifery practice**

From the time of the 1915 Midwives (Scotland) Act, midwifery practice in Scotland legally covered the care of mothers during normal pregnancy, labour and the postnatal period. In the early decades of the twentieth century midwives had little input into the care of pregnant women; their main remit lay in the care of mothers during labour and the postnatal period along with the newly born infant. By 1983, midwives still held a subordinate role in antenatal care, management of women in labour was controlled by members of the medical profession and postnatal care, particularly in hospital was subject to hospital policies.<sup>8</sup>

Yet, opinions of midwifery practice varied. There is tension between the views of Allison who argued that many midwives practising in Nottingham from 1948 to 1972 did so autonomously, and those of Oakley who emphasised the restrictions on them.<sup>9</sup> Evidence from the research for this thesis suggests that both are right. Their views highlight contrasts in midwifery practice which varied from place to place within the UK

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<sup>7</sup> See chapter 4, p 129.

<sup>8</sup> Scottish Health Service Planning Council, Shared Care in Obstetrics: A Report by the National Medical Consultative Committee, (Edinburgh: SHHD, 1983), para 1.6.

<sup>9</sup> J Allison, Delivered at Home, (London: Chapman and Hall, 1996); Oakley, The Captured Womb, see Introduction, pp 9 and 13; Gelda Pryde's oral testimony which includes information on her practice in Nottingham supports Allison's view. See Introduction, p 13 and chapter 7, p 262.

and between countries, for example, those of Continental Europe, as well as England and Scotland. Within Scotland these contrasts existed in all areas of midwifery practice.

Student midwives' Blue Books demonstrated contrasts in antenatal care from town to town varying from care in municipal clinics to no care at all. In rural areas, disparity also existed. Sometimes GPs and midwives appeared to work together as Ella Clelland demonstrated in Callander. However other oral testimonies revealed tensions where some GPs did not like working with certified midwives and some did not believe what the midwife had to say. As a further contrast, sometimes there was no certified midwife, and howdies looked after mothers in childbirth.

This thesis also reflects contrasts in what midwives were trained and officially permitted to do, and what they were allowed to do in practice. Oakley's comment that midwives were 'in danger of becoming mere handmaidens to obstetricians' is a fair point especially as hospitalisation of childbirth increased.<sup>10</sup> Yet oral evidence from midwives on the district revealed an initiative and confidence which diverges from the handmaiden theory. Nevertheless, the continuing issues of where and how women having a normal labour should give birth affected midwifery practice and the role of the midwife. Her role as a decision-making professional diminished and became blurred with the change in place of birth from home to the hospital labour ward, medical assumption of responsibility, the development of new technologies, hospital policies and protocols.<sup>11</sup> Midwives in hospital found themselves in an uncomfortable situation: they were pulled two ways between obeying hospital policy and mothers' primary needs.<sup>12</sup> Midwives

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<sup>10</sup> Oakley, *The Captured Womb*, p 76, see Introduction, p 9.

<sup>11</sup> R Mander, 'Autonomy in Midwifery and Maternity Care', in *Midwives Chronicle*, October, 1993, pp 369-374.

<sup>12</sup> S Hunt, A Symonds, *The Social Meaning of Midwifery*, (Basingstoke: Macmillan Press Ltd, 1995),

practising on the district had more freedom. They could take account of the individuality of mothers and their situations, and make their own decisions. But as the place of birth changed from home to hospital, the care for mothers over the whole childbearing episode became increasingly fragmented. The role of the community midwife, restricted for a time to postnatal care, became increasingly threatened and denigrated. Early discharge home of many postnatal mothers exacerbated the problem: this dictated the way community midwives practised, as in the time available they gave less care to more mothers.<sup>13</sup>

### **Shaping identity**

The 1915 Midwives (Scotland) Act gave midwives in Scotland a legal identity for the first time. Nevertheless the price for legal identity was an autonomy which, although contained within the Act, was in practice, nebulous and affected by the provisions of the Act. During the time of the CMB's existence from 1916 to 1983 the character of midwifery and the independence of midwives depended: on the will of the CMB; the changes brought about by successive relevant Acts; the changing management and practice of midwifery; and the attitudes of those with whom midwives worked and midwives themselves.

The paradox of legal autonomy of midwives and legal entitlement of women to choose their maternity care on the one hand, and overall control by the medical

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p 141; T Murphy-Black, 'Care in the community in the postnatal period', in S Robinson, and A Thomson, eds, Midwives, Research and Childbirth, Vol 3, (London and Glasgow: Chapman and Hall, 1994), pp 120-146.

<sup>13</sup> Murphy-Black, 'Care in the community in the postnatal period', pp 120-146; M McGuire, Community Postnatal Care Provision in Scotland: The Development and Evaluation of a Template for the Provision of Woman Centred Community Postnatal Care, unpublished PhD thesis, (University of Glasgow: 2001) p 28.

profession on the other, existed throughout the time of the CMB and led to tensions between obstetricians, GPs, midwives and women.<sup>14</sup> The CMB, while endeavouring to create a safer environment for mothers in Scotland by placing strict Rules on midwifery and eliminating the howdies for the sake of mothers and the livelihood of certified midwives, still insisted on the need for doctors to have overall control of maternity care. The attempt of the 1937 Maternity Services (Scotland) Act to co-ordinate maternity services advocated more partnership-working between maternity care professionals in all areas of expertise. This short-lived hope for something nearer to parity than midwives were enjoying at the time was dashed after World War II with the advent of the tripartite administration of the NHS, the rise of the GP as first contact for pregnant women, the increasing trend for hospital births and corresponding medicalisation of maternity care.

Improved education eventually brought more confident midwives although this took time. Midwives' power remained limited: the Board itself was answerable to the DHS (latterly the SHHD). Furthermore, within the Board, even as the number of midwives on the Board grew, they remained for a long time subordinate to the medical members. Margaret Kitson recalled: 'When I first joined the Central Midwives Board [in 1973] it was very, very medically dominated. It was necessary to begin with...just to sit down and be quiet and listen.'<sup>15</sup> In clinical practice, the erosion of midwives' responsibilities and skills became increasingly obvious after the coming of the NHS.

This thesis has only been able to touch on some aspects of the history of midwives in Scotland in the twentieth century. Nevertheless, it has brought to light

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<sup>14</sup> J Garcia, R Kilpatrick, and M Richards, eds, *The Politics of Maternity Care*, (Oxford: Clarendon Press, 1990), p 2; Mander, 'Autonomy in Midwifery and Maternity Care', pp 369-374.

<sup>15</sup> *Oral testimony*. For details of the oral interviews conducted in relation to this research, see Appendix 4. LR 41 [120]; see also chapter 5, p 182.



fluctuations in midwifery autonomy from 1916 to 1983, when the CMB oversaw midwifery training and practice in Scotland. These fluctuations can be attributed to: changes in legislation and practice in the care of pregnant and childbearing women; short-term events with long-term consequences like World War II and the implementation of the NHS; the input and opinions of those in other professions; the change in the geographic location of practice; and the actions and attitudes of midwives themselves.

In spite of variations in midwives' autonomy and freedom to make decisions about their practice, there were signs by the last decade of the CMB's existence that midwives' confidence in their professional abilities was developing. This was despite the fact that medicalisation of childbirth and midwifery as defined by van Teijlingen *et al* remained an obstacle.<sup>16</sup> Firstly, the improved education of midwives and midwife teachers helped midwives to feel more able to 'stand beside their medical colleagues'. This led to a lessening of medical domination. Secondly, the generations changed. Older obstetricians gradually retired and a more equal partnership between midwives and obstetricians developed.<sup>17</sup> Other examples of growing confidence are evident: Margaret Auld demonstrated immense conviction in her fight for a midwifery committee on the UKCC.<sup>18</sup> Confidence was progressively shown in the CMB too, as the number of midwife members grew and from 1977 to 1983 when midwives were Chair and Deputy.<sup>19</sup> And, confidence was revealed by the actions and attitudes of midwives like Jan Fenton in Dundee and Ella Clelland in Callander who used their initiative to improve their practice

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<sup>16</sup> E van Teijlingen, G Lowis, P McCaffery, M Porter, *Midwifery and the Medicalization of Childbirth: Comparative Perspectives*, (New York: Nova Science Publishers, Inc, 2000), p 1. See Introduction, p 14.

<sup>17</sup> LR, 41 [120]; chapter 6, p 220.

<sup>18</sup> LR 25 [105], see chapter 5, p 172.

and care for mothers.<sup>20</sup> Nevertheless what these midwives also showed was that to function fully as midwives they still required the blessing of the doctors with whom they worked.

So, the thesis reveals the developing confidence of the midwife, visible along with increasing autonomy by 1983, but suggests that to capitalise on this, midwives required the goodwill and confidence of themselves and each other, other professionals and women with whom they worked.

### **Future research**

Three of the many questions arising for future research have emerged above: 1. Why did the CMB appear to be reluctant to allow midwives to practise autonomously? 2. Why was the Board so unwilling to extend the midwifery training course? 3. And why was the CMB for Scotland so against non-nurses becoming midwives?

These questions could be answered in part at least, by interviewing more CMB members. As already noted, for the purpose of this thesis, I interviewed three midwives who had served on the CMB. I should like to interview these midwives again and other Board members, midwives, doctors and lay members, with the questions above in mind.

Such a study would make it possible to explore other questions about the CMB that emerge from this thesis. The Board, reflecting the mores of the time, always had a statutory majority of members of the medical profession over midwives. Until 1977 the Chairman of the Board was an obstetrician. It was only after Sheelagh Bramley became Chairman followed by Mary Turner that midwives on the Board felt able to contribute

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<sup>19</sup> See chapter 5, p 182.

<sup>20</sup>; LR, 40 [116], see chapter 6, p 218 and chapter 7, p 243; LR, 15 [9], see chapter 6, p 221.

freely. So, through further interviews with Board members and other midwives, I should also like to explore the attitude of the CMB towards midwives, on the Board, and in midwifery practice and education across Scotland. Did Board members and midwives see the CMB as a help or hindrance to the professional development of midwives?

## Postlude

The years after 1983 heralded further change both in statute and in midwifery practice. Nearly twenty years after the transfer of governance of midwives in Scotland from the CMB to the UKCC and the NBS, further statutory change in 2002 brought the Nursing and Midwifery Council (NMC) and NHS Education for Scotland to replace the previous bodies. Practically, the schemes for integration of maternity services marked the beginning of a positive response to consumer criticisms of the 1970s, which challenged the increasing medicalisation of birth and the apparent decreasing level of choice for women.<sup>21</sup> Thus, a breakdown of deference which began as early as the 1960s, gradually infiltrated into maternity care in general and midwifery in particular. This led to a change in attitude which became particularly visible from the late 1980s onwards. In 1993 the consultative document Maternity Services in Scotland: A Policy Review was published, heralding the change which became known as 'woman centred care'.<sup>22</sup> A Framework for Maternity Services in Scotland published in 2001 continued this aim and challenged the

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<sup>21</sup> M Hall, S MacIntyre, M Porter, Antenatal Care Assessed, (Aberdeen: Aberdeen University Press, 1985), pp 2, 8, 23; SHHD, Maternity Services: Integration of Maternity Work, (Edinburgh: HMSO, 1973).

<sup>22</sup> SHHD, Provision of Maternity Services in Scotland: A Policy Review (Edinburgh: Her Majesty's Stationery Office, 1993).

NHS to provide an essentially community based, midwife managed service with easy access to specialist services wherever needed.<sup>23</sup>

Nevertheless to build on and maintain partnership and team working, requires the willingness of all concerned. At an RCM UK Board for Scotland Think Tank Day, Margaret McGuire quoted Dame Lorna Muirhead, RCM President when she said, 'The war is over'.<sup>24</sup> To maintain this peace, midwives still require the goodwill of the medical profession, the acceptance of mothers and confidence in themselves and each other.

The 1915 Midwives (Scotland) Act which framed the legislation for the CMB, was part of the Maternity Services Schemes in Scotland, formed to improve the care and birth outcome of mothers and babies in Scotland. In 2002, while the legislation and statutory bodies have changed, the objectives remain the same.

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<sup>23</sup> Scottish Executive Health Department, A Framework for Maternity Services in Scotland, (Edinburgh: Scottish Executive, 2001).

<sup>24</sup> M McGuire, 'Normality in Professional Practice', presented at RCM UK Board for Midwives Think Tank Day, Facing the Future – the Agenda for Midwives, Edinburgh, 12 July, 2002.

## Appendix 1

### Using Oral History as a Methodology

Oral history, a method of qualitative research, has become increasingly popular since the 1970s. It consists of one or more persons narrating, often in an interview situation, an account of a life-story or an event, usually in the past, to someone, usually a researcher, who listens and asks relevant questions as the interview progresses. It is current normal practice for the researcher to record the interview, transcribe the recording either in full or in part, and analyse the findings.

Oral history has considerable potential for the history of midwives. Oral history, now an accepted form of historical research, is used to obtain information where little documented evidence exists or where the documented evidence is one-sided or suspect. It also revises history by challenging an accepted, usually written, view of an issue. Midwives did not traditionally write down their experiences and there is much that remains unknown about past midwifery practice. Billie Hunter argued that it is relevant for current midwives to elicit what has gone before in this way, to expand their knowledge and enhance their practice.<sup>1</sup> The written archival sources I have for the history of midwifery in Scotland omit details of midwifery practice and the careers of midwives. It therefore seemed appropriate, to use oral history to examine the work and career histories of midwives in Scotland in the comparatively recent past.<sup>2</sup>

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<sup>1</sup> B Hunter, 'Oral History and Research Part 1: Uses and Implications', *British Journal of Midwifery*, July 1999, Vol 7, No 7, p 426.

<sup>2</sup> I also explored the background to oral history taking specific references from: P Thompson, *The Voice of the Past*, 2<sup>nd</sup> ed, (Oxford: Oxford University Press, 1988) p 23, 26, 189; E Dwelly, *The Illustrated Gaelic-English Dictionary* (Edinburgh: Birlinn, 1993), p 798. (First Published, 1901-1911); R Perks and A Thomson, eds, *The Oral History Reader*, (London: Routledge, 1998), p 1; J Bornat, 'Oral History as a Social Movement: Reminiscence and Older People', in *Oral History*, Vol. 17 No 2. Autumn 1989, p 16; W Storrar, *Scottish Identity: A Christian Vision*, (Edinburgh: The Handsel Press, 1990), p 240, 241; N Leap,

This appendix describes how I have used oral history to illuminate the history of Scottish midwives in the twentieth century. I examine issues of recruiting interviewees and how these worked for this project; I look at 'the interview', and discuss the appropriateness of single and multiple interviews, and other practical and ethical aspects of interviewing.

### **Recruiting and interviewees**

I recruited interviewees in several ways. Initially, I wrote to many Scottish newspapers and journals appealing for information about midwives, midwifery and childbearing in twentieth century Scotland. The responses, by letter and by telephone, came mostly from midwives and relatives of deceased midwives in Scotland. I filed all the letters and details of phone-calls according to a contact number.

Sometimes one midwife introduced another who was prepared to be interviewed. This is called 'snowballing'.<sup>3</sup> I found that retired midwives in particular, used snowballing because they had known each other for a long time and were aware of each other's area of expertise which might be useful.

I also asked midwives directly for an interview by telephone or letter, either through knowing them personally or through a contact. A letter was more formal and possibly, in some instances, more 'correct'; however, a telephone call gave direct vocal contact and sometimes engendered more enthusiasm than a letter. Also, it helped to be

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and B Hunter, *The Midwife's Tale: An Oral History from Handywoman to Professional Midwife*, (London: Scarlet Press, 1993), p 191; P Summerfield, *Reconstructing Women's Wartime Lives* (Manchester: Manchester University Press, 1998), p 10; E Breitenbach and E Gordon, eds, *Out of Bounds. Women in Scottish Society 1800-1945*, (Edinburgh: Edinburgh University Press, 1992), p 2.

<sup>3</sup> For an example of the use of this method in a study of the history of women in the coalmining industry, see: A V John, 'Scratching the Surface: Women, Work and Coalmining History in England and Wales', in *Oral History*, Vol.10, No 2, Autumn 1982, pp 13-26.

able to say that somebody else in the informant's own network had recommended her.<sup>4</sup> In addition, I recruited at conferences, seminars, and workshops.

It was appropriate to recruit and choose interviewees to fit in with the period of the study defined by two key pieces of legislation affecting the organisation of midwifery. The period began with the implementation in 1916 of the 1915 Midwives (Scotland) Act and ended in 1983 with the implementation of the 1979 Nurses, Midwives and Health Visitors Act and the dissolution of the CMB.<sup>5</sup> Recruitment of interviewees could not cover the whole period. (Table A1.1)

**Table A1.1     Distribution of Midwife Interviewees  
by Year Qualified**

<b>Year qualified</b>	<b>No of interviewees</b>
1928	1
1931	1
1934	2
1939	1
1940	2
1941	1
1942	1
1943	1
1944	1
1945	3
1946	3
1947	3
1952	2
1953	1
1955	3
1957	3
1958	2
1961	2
1962	1
1969	2
1970	1

<sup>4</sup> Paul Thompson, *Voice of the Past*, p 206.

<sup>5</sup> *1979 Nurses, Midwives and Health Visitors Act*, Chapter 36 ( London: HMSO, 1979).

1974	1
1977	1
1981	2

The oldest certified midwife was ninety-six when interviewed, and qualified as a midwife in Edinburgh in 1928.<sup>6</sup> The gap of twelve years between 1916 when the CMB started enrolling midwives and 1928 is partly closed by written information from relatives of deceased midwives. Two of the midwives were uncertified, or howdies, and because of their scarcity, their testimonies are of particular interest. As midwifery is a gender-biased occupation, the interviewees with one exception were women. I chose interviewees to cover as wide a range as possible chronologically, in different types of practice, and geographically within Scotland. Primary details of the interviews are in the table in Appendix 4. They are listed first in the order of the interview. The second column: No in file, refers to where the interviewee is in my personal file which covers all contacts I have made for this study. This includes records of telephone conversations and letters as well as details of the forty-five interviewees.

A notable feature about most of the interviewees was their pleasure and satisfaction in their work. Another oral historian observed that ‘women who came forward to be interviewed were likely to be those who enjoyed their work’, and this I found to be true.<sup>7</sup> Nevertheless, there were a few who demonstrated the opposite. One South African who trained as a midwife in Glasgow in 1934 acknowledged that her training was ‘very interesting’ but refused a post in midwifery as she ‘hadn’t enjoyed

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<sup>6</sup> Oral Testimony. For details of the oral interviews conducted in relation to this research, see Appendix 4. LR, 19 [47].

<sup>7</sup> John, Scratching the Surface, pp 13-26.



doing midwifery and...didn't really want to carry on.'<sup>8</sup> One midwife volunteered to be interviewed because of her disquiet with her midwifery training in the mid-1970s, her distress at what routine medicalised maternity care was doing to women in that unit at the time, and her desire to enlighten others of the situation.<sup>9</sup> She also found it helpful to read and re-read the edited transcript of her testimony. The therapeutic use of transcripts is not specifically mentioned in oral history literature that I have read, though there is discussion of the psychological aspects of the interview itself.<sup>10</sup>

Thus, interviewees can use the interview situation as a means of making a point. The one male midwife interviewee appeared keen to show that a man could make a good midwife and used his oral testimony as a platform for this. 'I was so immersed in the job...you never thought of yourself as being anything different or of gender at all...One of my colleagues...said I changed her view [of men in midwifery]'.<sup>11</sup> Most respondents gave no reason for agreeing to be interviewed other than to help with the project. As historians have not previously recorded midwifery history in Scotland to any great extent, some saw it as particularly worthwhile and used phrases like, 'Anything to help the cause.'<sup>12</sup>

## The Interview

Oral history can be divided into distinct types. Firstly, there are 'life histories,' which allow the interviewee to narrate the aspects of his or her life-story, sometimes for

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<sup>8</sup> LR, 22 [50].

<sup>9</sup> LR, 20 [85].

<sup>10</sup> Thompson, 'Memory and the Self', in *Voice of the Past*, pp 152-165.

<sup>11</sup> LR, 17 [88]; Until 1975 it was illegal for any man to practise midwifery unless he was a medical practitioner or in an emergency. The 1975 Sex Discrimination Act permitted men to train and practise as midwives.

<sup>12</sup> *Telephone conversation*, LR, [20].

inclusion in a book, or to add to an archival collection. Life histories usually require multiple interviews to give the interviewee time and space to explore the past.<sup>13</sup> In contrast, there is the 'single issue' interview highlighting a particular incident or period in a person's life. There are also 'specific histories', covering a significant part of the interviewee's life, for example, in the case of this project, the 'career histories' of midwives. The ideal of more than one interview was not usually feasible for this project, because of time constraints involving distances and travelling, transcribing, and analysis of transcripts. Yet, I occasionally asked for more than one interview. I spoke to one midwife without recording her and returned to her two years later with the tape-recorder. This worked well, highlighting the benefit of a 'warm-up' session. On two occasions the recording equipment was not working properly and I contacted the interviewees, apologised and asked for another interview. On each of these occasions, although a repeat session, the second interviews went well. On another occasion, on the Isle of Harris, the interviewee was eighty-nine and we had not met for twenty-six years. An initial informal visit preceded two recording sessions, the second of which was noticeably more relaxed than the first. These experiences confirm that the ideal is to visit/interview each respondent more than once. However, I obtained a considerable amount of information from the single interviews. Many people enjoyed telling their story once they started and to be interviewed made a respondent feel the centre of attention. One retired midwife in her eighties said as she escorted me up to her flat, 'you know, this is a very exciting day for me'. This reminded me that while the interviewee was giving something to the

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<sup>13</sup> Thompson, *Voice of the Past*, p 207; P Thompson, 'Session on Interviewing' at the *Oral History in the History of Medicine Course*, Oxford, 18-22 October, 1999; H Slim, P Thompson, O. Bennett, N. Cross, 'Ways of Listening', in R Perks and A Thomson, eds, *Oral History Reader*, (London: Routledge, 1998), p 116.

interviewer, she was also gaining: company, possibly a feeling of importance, the chance to talk to someone who understands what she has done and to discuss the 'old days'.

I attempted to carry out the interviews in the place where the interviewee, often quite elderly, would feel most at ease. This was usually her own home, or in the case of someone being cared for, where she usually is, whether it was her bedroom or sitting room.<sup>14</sup> Here, she had the safety of being in her own surroundings. Also, in these circumstances, the interviewee is the hostess, feels in charge and usually derives pleasure from being in this situation and dispensing hospitality. Some practising midwives chose their office for the interview, and practicalities dictated that one interview was held in a conference centre after the meeting had dispersed.

In most instances it is best to be alone with the respondent; complete privacy encourages an atmosphere of trust which engenders open-ness.<sup>15</sup> However, occasionally the interviewee arranged for another midwife to be present. Interviewees reminded each other as they talked of memories of their midwifery training which enhanced rather than detracted from the value of the interview for my purposes. Another time, the 'main' interviewee was very articulate while the other was quieter, but as the latter adjusted to the situation she had a very interesting tale to tell. On another occasion, the interviewee's elderly sister sat in on the interview, which turned out to be helpful for checking facts, and did not appear to intimidate the interviewee. Finally on one occasion I recorded the discussion of a group of retired midwives around a kitchen table and found this a highly useful way to gather a large amount of information.<sup>16</sup>

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<sup>14</sup> Thompson, *Voice of the Past*, p 205.

<sup>15</sup> *Ibid.*

<sup>16</sup> *Ibid.*, pp 205-206 discusses the advantages and dangers of interviewing more than one interviewee at a time.

It is also helpful for the researcher and respondent to discuss the optimum length of an interview beforehand; much depends on how the interviewee copes with the situation, her age and how tired she becomes. For this project, the length of interviews varied between 1 ¼ and 2 hours. A few were shorter than this and in the occasional longer one, there was a break and a second session.

Another important consideration, especially with elderly respondents, was the best time of day for the interviewee. This was particularly apparent when visiting my oldest respondent aged ninety-nine. Her grand-daughter asked me to visit at coffee-time as by then her grandmother would be up and at her most alert.

The outcome of an interview also depends on how much the interviewer knows. The interviewer can be an 'outsider', a 'naïve interviewer', ready to ask intelligent questions but does not know about the subject. However, from this 'innocent standpoint', the outsider can glean much information. Or, the interviewer can be an 'insider', a 'native interviewer', who knows about the subject, is possibly in an easier position and may achieve perhaps better, but usually different results. An interviewee, knowing that interviewer is an insider, may be more likely to respond more openly.<sup>17</sup> Two incidents in the course of this research illustrate this point. In the first, the interviewee said, 'are you a midwife yourself?' When I said, 'yes', she said, 'oh well then...' Thus, she acknowledged my 'insider' status and probably spoke more freely because of this.<sup>18</sup> From the interviewer's perspective, I learned that I must make my background clear at the outset. On another occasion, the interviewee commented how much she had enjoyed speaking about her career as a midwife in the 1940s, something she seldom was able to

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<sup>17</sup> J Stanton and P Thompson, Teaching Session: Oral History and the History of Medicine, in the Course: 'Oral History and the History of Medicine', Oxford, 18-22 October, 1999.

do, as others did not want to hear her stories. Also, midwifery, and birth and its intimacies, were not subjects one could discuss with everyone.<sup>19</sup>

### **Questionnaires, interview guides and memory aides**

The use of questionnaires, key words and other memory aides depends upon the structure of the interview. The interviews for this project were informal and each one differed from the others, mainly because the interviewees covered a wide age-range and different time-periods. Therefore specific midwifery issues varied depending on the interviewee. Quite early in the project I wrote a questionnaire to clarify my thoughts and to ascertain what I wanted to find out that I could not obtain from written sources. I used the questionnaire to assist me in preparation for an interview. Before every interview I thought about the interview, the interviewee, her age, when she practised and whether there was anything about that period which might specifically have impacted upon midwifery practice. Also, I usually wrote key words as a personal *aide memoire*, and during the interview I noted for later discussion, issues that arose rather than interrupt the flow. I did not take copious notes as these were recorded interviews.

Thus, apart from initial personal details, interviews for this project varied according to the interviewee. They covered training, practice, job changes and aspects of midwifery that particularly interested the interviewee along with particular issues about which I wanted to ask, for example: 'How did midwives feel about the decline in home deliveries?' Most interviewees asked for guidance as to issues for discussion. With this help, most were very willing to recount their memories and rewarded open-ended

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<sup>18</sup> LR, 35 [27].

<sup>19</sup> LR, 27 [93].

questions, for example: 'Why do you think mothers were reluctant to go to antenatal clinics?' with some wide insights into midwifery in varying periods.

### **Practicalities**

Because of financial constraints, equipment for this project was basic and inexpensive. It consisted of a Sony flat cassette recorder, model TCM-939, which worked with batteries or mains electricity and an external flat-based microphone requiring lithium batteries. Audio-tapes were standard ninety minute, forty-five minutes per side. Labelling of tapes included the interviewee's name and personal number according to the contact file. On the box, was the name, number, address and age of the interviewee, the date of interview, and number of tape, for example, one of two.<sup>20</sup> Tapes are currently stored in number order in a safe place at my home.

When transcribing the interviews I used in-the-ear head-phones. Provided the recording was reasonable, the only problem with transcribing was the length of time it took. This could be from six to twelve hours for one hour of recording.<sup>21</sup> It was important to me to do the transcribing myself, partly to do with financial constraints, but, more significantly, I felt the need to relive the interview, to listen again and remember what the interviewee had said. As a further aid I constructed an alphabetical card index system corresponding to midwifery issues which interviewees discussed on tape. This enabled me to find a specific oral testimony by the transcription page number and was useful when drawing on the oral testimonies as examples.

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<sup>20</sup> This followed advice given at the oral history course in Oxford, October 1999.

<sup>21</sup> Thompson, *Voice of the Past*, p 228.

## **Ethical issues**

When using oral history as a research tool, there are ethical considerations. One of the main issues is informed consent. I made sure that the interviewees were aware of and gave their consent to: the purpose of the research; any further use to which the tapes might be put, for example in any further publication; deposit and storage of the tapes in a safe place, for example, an archive, as a permanent public reference resource for possible use in research, publication, education, lectures and broadcasting. To cover these issues I asked the interviewees to sign a consent form, completely or in part. If they felt unable to do this we discussed what they would like to do with their tapes and transcription. Three interviewees placed conditions on the use of the material: one wants the tape to be destroyed and the transcription deleted when this piece of research is finished. The other two want the tapes returned to them. All the other interviewees agreed to the consent form and signed it.

Other important issues were anonymity and confidentiality. I asked each of my interviewees if I could use their names when using their testimonies. Of those, two want to remain completely anonymous; all the others have agreed to my using their names in this project where appropriate.

## Appendix 2

Members of the Central Midwives Board for Scotland 1916-1983 showing years of service as a Board member, the appointing body and status.

Name of CMB member	Year appointed	Year demitted	Appointing person or body	Doctor, Midwife or lay
Lady Balfour	1916	1919	Lord Pres of PC	Lay
Sir Archibald Buchan-Hepburn	1916	1930	Assoc of CC for Scotland	Lay
Sir Robert Kirk Inches	1916	1918 (died)	Con RB in Scotland	Lay
Lady Susan Gordon Gilmour	1916	1921	QVJIN	Lay
Archibald Campbell Munro	1916	1923 (died)	SMOHS	Doctor
Sir J Halliday Croom	1916	1921	UC Edin and St And	Doctor
Murdoch Cameron	1916	1921	UC Glas and Abd	Doctor
James Haig Ferguson	1916	1934 (died)	RCOP Edin, RCOS Edin, RCOPS Glas; 1921 QVJIN; 1926 RCOP Edin, RCOS Edin, RCOPS Glas	Doctor
Michael Dewar	1916	1926 (died)	BMA (Scot Com)	Doctor
John Wishart Kerr	1916	1921	BMA (Scot Com)	Doctor
Alice Helen Turnbull	1916 (July)	1933	Lord Pres of PC (1919 SBH)	Midwife
Isabella Lewis Scrimgeour	1916 (July) Re-app 1927	1926  1928 (died)	Lord Pres of PC (1919 SBH); SBH	Midwife
Sir John Lorne MacLeod	1918	1921	Con RB in Scot	Lay
Lady Helen Hermione Munro-Ferguson	1919	1921	Lord Pres of PC	Lay
Kate Leslie Scott	1921	1926	SBH	Midwife
Sir Robert Cranston	1921	1924	Con RB in Sco	Lay
J A C Kynoch	1921	1926	UC Edin and St And	Doctor
Robert Gordon McKerron	1921 Re-app 1931	1926  1936	UC Glas and Abd UC Glas and Abd	Doctor
Robert Jardine	1921	1926	RCOP Edin, RCOS Edin, RCOPS Glas	Doctor
E H L Oliphant	1921	1926	BMA (Scot Com)	Doctor
Archibald Kerr Chalmers	1923	1941	SMOHS	Doctor
Sir Malcolm Smith	1924	1926	Con RB in Scot	Lay
Mary E Cairns	1926	1940	SBH, later DHS	Midwife
Ella M Millar	1926	1941	Con RB in Scot	Lay
Margaret M White	1926	1931	QVJIN	Midwife
B P Watson	1926	1926	UC Edin and St And	Doctor
John M Munro Kerr	1926	1931	UC Glas and Abd	Doctor
Robert C Buist	1925	1939 (died)	BMA (Scot Com)	Doctor
James B Miller	1926	1936	BMA (Scot Com)	Doctor
Robert W Johnstone	1926 Re-app 1936	1931  1953	UC Edin and St And UC Edin	Doctor
Lillias Ann D Wishart	1929	1939	SBH	Midwife



Rt Hon Lord Polwarth	1930	1936	Assoc of CC for Scotland	Lay
Isabella Cromarty Dewar	1931	1946	QVJIN /QIDNS	Midwife
John McGibbon	1931	1941	UC Edin and St And	Doctor
George Wallace	1933	1936	DHS	Lay
Douglas Alexander Miller	1934	1936	RCOP Edin, RCOS Edin, RFOPS Glas	Doctor
Peter Taylor	1936 Re-app 1942	1939  1943	DHS	Lay
James Hendry	1936	1945	UC Glas	Doctor
R J Thomson	1936	1939	Assoc of CC for Scot	Lay
James Cook	1936	1939	BMA (Scot Com)	Doctor
Donald McIntyre	1936	1941	RCOP Edin, RCOS Edin, RFOPS Glas	Doctor
Margaret Rachel Gouk	1937	1946	DHS	Midwife
Margaret Wilson Risk	1937	1946	DHS	Midwife
George Henry Kimpton	1937	1939	DHS	Lay
Dugald Baird	1937 Re- app 1961	1951 1962	UC Abd; 1961, SOS for UC Abd, Edin, Glas, St And	Doctor
Robert Howat	1939	1941	DHS	Lay
Frances Ann Wilkinson Allan	1939	1948	DHS	Midwife
J D Tod	1939	1941	Assoc CC for Scot	Lay
David Dale Logan	1939	1953	BMA (Scot Com)	Doctor
William Leslie Cuthbert	1939	1953	BMA (Scot Com)	Doctor
Mary McGhie	1940	1952	DHS	Midwife
Clarice M M Shaw	1941	1946	Assoc CC Scot	Lay
David Robertson	1941	1949	Con RB in Scotland	Lay
Sir Alexander Stuart Murray MacGregor	1941	1948	SMOHS	Doctor
Margaret Fairlie	1941	1953	UC St And	Doctor
William Francis Theodore Haultain	1941 Re-app 1953	1951  1958	RCOP Ed, RCOS Edin, RFOPS Glas RCOG	Doctor
J Y Sutherland	1943	1944	DHS	Lay
T A Grieg	1944	1947	DHS	Lay
Isa Hamilton	1946	1952	QIDNS	Midwife
Jean P Ferlie	1946	1963	SOS ; 1953, Cert mids prac in Scotland	Midwife
J A Fisher	1946	1958	Assoc C C Scot; later, SOS for Assoc C C Scot, Con RB, Scot C of C Assoc	Lay
Robert Aim Lennie	1946	1960	UC Glas; later SOS for UC Abd, Edin, Glas, St And	Doctor
N D Walker	1947	1948	SOS	Lay
A S McDermid	1948	1951	SOS	Midwife
J Cochrane	1948	1953	SOS	Lay
Janet Love	1948	1953	SOS	Midwife
William Leslie Burgess	1948	1949	SMOHS	Doctor
Nora Wattie	1949	1968	SMOHS	Doctor

C McGregor	1951	1953	SOS	Midwife
J Gibson	1951	1953	Con RB in Scotland	Lay
George Panton Milne	1951 Re-app 1973	1954  1978	UC Abd SOS	Doctor
David MacKay Hart	1951	1973	RCOP Edin, RCOS Edin, RFOPS Glas (1954 SOS for these bodies), 1959, RCOG	Doctor
J Bruce Dewar	1953	1968 (died)	SOS	Doctor
J H Beckett	1953	1961	Cert mids prac in Scot (In 1961, app Education Officer to the Board) Ret 1973	Midwife
Phyllis Bennett	1953	1960	Cert mids prac in Scot	Midwife
Elsie Renwick	1953	1968	Cert mids prac in Scot	Midwife
J Wolrige Gordon	1954	1968	SOS	Lay
J M Steel	1954	1959	SOS	Midwife
J Stenhouse	1954	1959	SOS	Midwife
M J A Urquhart	1954	1959	SOS	Midwife
Mary McAllister	1954	1959	SOS for Assoc CC Scot, Con RB, Scot C of C Assoc	Lay
Catherine Harrower	1954	1961	BMA (Scot Com)	Doctor
Sheelagh P O Bramley	1959 Re-app 1968	1963  1978	SOS  SOS	Midwife
Mary Fraser	1959	1966	SOS	Midwife
Katie Watt	1959	1963	SOS	Midwife
E Chalmers Fahmy	1959	1963	SOS for RCOP Edin, RCOS Edin, RFOPS Glas	Doctor
R Burnside	1959	1962 (died)	SOS for Assoc CC Scot, Con RB, Scot C of C Assoc	Lay
Charles W Norman	1959	1963	SOS for Assoc CC Scot, Con RB, Scot Cof C Assoc	Lay
E M H Burrows	1960	1973	Cert mids prac in Scot	Midwife
Hugh B Muir	1961	1968	BMA (Scot Com)	Doctor
Margaret M Grieve	1961	1963	Cert mids prac in Scot	Midwife
G Douglas Matthew	1963	1978	SOS for UC Abd, Edin, Glas, St And 1963, SOS for SUC	Doctor
Margaret J W Taylor	1963	1968	SOS	Midwife
Ellen Hodge	1963	1973	SOS	Midwife
T N MacGregor	1963	1973	SOS for Medical Corporations	Doctor
J Kelly	1963	1968	SOS for LA Assoc	Lay
M B A Ross	1963	1966	SOS for LA Assoc	Lay
H H Conner	1963	1968	Cert mids prac in Scot	Midwife
J M Lamont	1963	1973	Cert mids prac in Scot, 1968, SOS	Midwife
W E Donaldson	1966	1978	SOS for LA Assoc	Lay
R Gatt	1966	1973	SOS	Midwife
R M Bernard	1968	1973	SOS	Doctor
C J Tudhope	1968	1978	SOS	Lay

Ena Logie	1968	1970	SOS for LA Assoc	Lay
Margaret C Barron	1968	1978	SBMOH later, Scot Affairs Cttee of the Faculty of Comm Med	Doctor
Joseph McGlone	1968	1973	SCBMA	Doctor
Annie S Grant	1968	1973	Cert mids prac in Scot App Education Officer to the Board 1 Aug 1973, ret Aug 1982	Midwife
N J Stephen	1968	1973	Cert mids prac in Scot	Midwife
A J Gardner	1970	1971	SOS for LA Assoc	Lay
Mary McCue	1971	1974 (died)	SOS for LA Assoc	Midwife
V M Bremner	1973	1976	SOS	Midwife
Maureen M Baird	1973	1976	SOS	Midwife
John D O Loudon	1973	1978	SOS for Medical Corporations	Doctor
John M Crawford	1973	1976	RCOG	Doctor
W A Ross	1973	1975	SCBMA	Doctor
Margaret G Auld	1973	1977	Cert mids prac in Scot	Midwife
Lena Margaret Kitson	1973	1983	Cert mids prac in Scot	Midwife
Mary M Turner	1973	1983	Cert mids prac in Scot	Midwife
M M Bicker	1973	1983	CMB app for Cert mids prac in Scot, 1978, SOS	Midwife
C R Playfair	1975	1983	SOS for LA Assoc and 1978, for Health Boards	Midwife
John MacKay	1976	1983	SCBMA	Doctor
Marjorie E Marr	1976	1983	SOS, 1978, Cert mids prac in Scot	Midwife
Anne D Dewing	1977	1980	SOS	Midwife
M Mackay	1977	1978	CMB app for Cert mids prac in Scot	Midwife
John W Crawford	1977	1981	RCOG	Doctor
George Gordon	1978	1983	SOS	Doctor
E T Gourlay	1978	1983	SOS	Midwife
M D Wardle	1978	1983	SOS	Midwife
James Willocks	1978	1981	SOS for RMC	Doctor
H T Falconer	1978	1983	SOS for Health Boards	Midwife
Hamish W Sutherland	1978	1983	SOS for SUC	Doctor
Murdoch Murchison	1978	1983	Scot Affairs Cttee of the Faculty of Comm Med	Doctor
M L Brown	1978	1983	Cert mids prac in Scotland	Midwife
Mary L Taylor	1980	1983	SOS	Midwife
P R Myerscough	1981	1983	SOS for RMC	Doctor
N B Patel	1981	1983	RCOG	Doctor

**Key:**

Assoc of CC for Scotland:	Association of County Councils for Scotland
BMA (Scot Com):	British Medical Association, Scottish Committee
Cert mids prac in Scot:	Certified midwives practising in Scotland
Con R B in Scotland:	Convention of Royal Burghs in Scotland
DHS:	Department of Health for Scotland
LA Assoc:	Local Authority Associations
Lord Pres of P C:	Lord President of the Privy Council
SMOHS:	Society of Medical Officers of Health for Scotland
QIDNS	Queen's Institute of District Nursing (Scottish Branch)
QVJIN:	Queen Victoria Jubilee Institute of Nurses (Scottish Branch)
RCOP Edin:	Royal College of Physicians of Edinburgh
RCOS Edin:	Royal College of Surgeons of Edinburgh
RCOPS Glas:	Royal College of Physicians and Surgeons of Glasgow
RFOPS Glas:	Royal Faculty of Physicians and Surgeons of Glasgow
RMC:	Royal Medical Colleges
SBMOH:	Scottish Branch of Medical Officers of Health
SCBMA:	Scottish Council of the British Medical Association
Scot C of C Assoc:	Scottish Counties of Cities Association
SOS:	Secretary of State for Scotland
SOS for eg Health Boards etc:	Secretary of State for Scotland on behalf of, for example, Health Boards etc
SUC:	Scottish University Courts
UC Edin and St And:	University Courts of the Universities of Edinburgh and St Andrews
UC Glas and Abd:	University Courts of the Universities of Glasgow and Aberdeen

## Appendix 3

### Chairmen of the Central Midwives Board for Scotland 1916-1983

Name	Qualifications and degrees.	Main places of work	Years as Chairman
Prof Sir J Halliday Croom	MD	Professor of Midwifery at University of Edinburgh Obs and Gyn RIE	1916-1921 (Died 1923)
James Haig Ferguson	MD, FRCP Edin, FRCS, Edin, FRSE, LLD	Visiting physician to prematernity home for unmarried mothers, open Edin 1899, latterly in 4 Lauriston Park and known as Haig Ferguson Memorial Home, Edinburgh On staff of RIE President of EOS: 1911-1912, 1928-1929 Specialty: antenatal care <sup>1</sup>	1921-1934 (Died 1934)
Robert Cochrane Buist	MA, MD	Consultant Obs And Gyn Dundee Royal Infirmary	1934-1937 (Died 1937)
Professor R W Johnstone	CBE, MA, MD, FRCS Edin, MRCP Edin	Assistant Obs And Gyn 1922-1926; Prof of Midwifery and the Diseases of Women, University of Edinburgh; Obstetrician and Gynaecologist, RIE (1926-1946) Retired 1946 <sup>2</sup>	1937-1953 (Died 1969)
Professor Robert A Lennie	TD, MD, FRFP & SG, FRCOG	Lecturer, Glasgow Royal Infirmary Medical School, St Mungo's College 1928 Consultant Obstetrician, 1948-1954, Glasgow Royal Maternity and Women's Hospital Regius Chair of Midwifery 1946-1954 <sup>3</sup>	1953-1960 (died March 1961)
James Bruce Dewar	OBE, FRCS Edin, FRCS Glas, FRCOG, JP	Consultant Obs and Gyn, 1939-1945 RIE <sup>4</sup> Consultant Obs and Gyn, Crichton Memorial Hospital, Dumfries	1960-1968 (died later 1968)
G Douglas Matthew	FRCOG, FRCS Edin	Consultant Obstetrician and Gynaecologist, RIE, 1946-1974 <sup>5</sup>	1968-1977
Sheelagh P O Bramley	SRN, SCM, MTD, DNA	Qualified in London Worked in South Africa; DipMid Witwatersrand University; MTD Kingston upon Thames; Clin Instructor and Lab Ward Supervisor, Aberdeen; Studied in Australia; 1959-1976 Matron and Head of School of Midwifery, Bellshill Mat Hospital; 1976 Head of Service/ Div NO, Ret 1980s, Early 1970s on Tennent Committee <sup>6</sup>	1977-1978
Mary M Turner	RFN, RGN, SCM, MTD, Dip Nurse Admin	Qualified RFN in Knightswood Hospital, Glasgow and RGN in Glasgow Royal Infirmary. SCM 1948 Ayrshire Central Hospital, (ACH), 1952 MTD at GRMH. Worked as midwife teacher in GRMH and ACH before becoming Assistant Matron ACH; 1965-83: Matron and Head of Midwifery School at Aberdeen Maternity Hosp. Later Div Nursing Officer. <sup>7</sup>	1978-1983

<sup>1</sup> J Sturrock, *The Edinburgh Royal Maternity and Simpson Memorial Hospital*, Reprinted from the *Journal of the Royal College of Surgeons of Edinburgh*, Vol 25, May 1980, pp 173-187.

<sup>2</sup> E Catford, *The Royal Infirmary of Edinburgh 1929-1979*, Scottish Academic Press, Edinburgh 1984, p 271.

<sup>3</sup> D Dow, *The Rottenrow The History of the Glasgow Royal Maternity Hospital 1834-1984*, (Carnforth: The Parthenon Press, 1984), pp 138, 180, 181.

<sup>4</sup> Catford, *The Royal Infirmary of Edinburgh*, p 272.

<sup>5</sup> Catford, *The Royal Infirmary of Edinburgh*, p 272.

<sup>6</sup> E Caldwell, *Sixty Glorious Years*, (Paisley: 1981), pp 35-36.

<sup>7</sup> Details provided by Miss Mary Turner.

## Appendix 4

### Summary of Interviews for Oral History Purposes between 1997 and 2002

No of interview	No in file	Method of initial contact	Approx age at interview	Date of interview	Description at interview	Length of interview	Location of interview	Site of interview	Training hospital	Year registered	Areas practised as a midwife (in Scotland)	How – hospital, community etc.
1	20	Phone	79	27.5.97 26.3.00	Very helpful. 1st visit not recorded	1 ¼ hours 2 hours	Dundee	Own home	Lennox Castle	1947	Dundee	Three different hospitals
2	11	Phonecall	83	6.6.97	Forthcoming Found WW2 difficult to talk about	2 hours	Auchtermuchty, Fife	Own home	GRMH	1940	GRMH, Lanarkshire CC	Hospital/district
3	2	Letter	mid-80s	18.8.97	Friendly, forthcoming	2 hours	Wick	Own home	GRMH and Motherwell	1945	Johnstone, Wick	Hospital
4	115	Via no1	mid-80s	18.8.97	Enthusiastic, forthcoming	2 hours	Wick	Home of No 3	GRMH	1945	Glasgow, Wick	Hospital
5	56	Word of mouth	92	21.8.97	Most enthusiastic	2 hours	Unst, Shetland	In own home	Aberdeen Maternity Hospital	1931	Fetlar, Raasay, Unst	Queen's Nurse, on district
6	61	Letter	80	26.8.97	Friendly	2 hours	Aith, Shetland	In own home	Local historian	N/A	N/A	N/A
7	80	Letter in response to newspaper letter	80s	Sept 97	Interested in this research.	N/A	California	Own home	Aberdeen	1940	Not known Short interview by friend in California	Not known

8	43	Letter in response to newspaper letter – then organised 9,10,11 to meet together.	60s	26.10.97	Keen to tell story	1 ½ hours	Dunfermline, Fife	Own home	Dunfermline	1957	Group 8-11 spoke about midwifery training in Dunfermline	
9	82		60s	26.10.97	Quiet but relevant comments.	1 ½ hours	Dunfermline, Fife	In home of no 8	Dunfermline	1957		
10	83		60s	26.10.97	Talkative	1 ½ hours	Dunfermline, Fife	In home of no 8	Dunfermline	1957		
11	84		70s	26.10.97	Also keen to talk.	1 ½ hours	Dunfermline, Fife	In home of no 8	Dunfermline	1958 Direct entry		
12	74	Letter	N/K	4.12.97	Helpful	1 hour	Perth	In office, at work	Perth RI	1974	Perth	Hospital, mainly
13	46	Word of mouth/phone	90	2.4.98	Formal but happy to talk	1 ½ hours	Edinburgh	Own home	SMMP	1934	HQ Rutland St, Ed. Cases widespread	Private, on district
14	10	Phoned in response to letter in newspaper	60s	15.4.98	Very talkative Much of the recording is irrelevant to this study	1 ½ hours	Glenrothes	Own home	N/A	N/A	N/A	Not a midwife, but grannie was an uncertified midwife who worked in NE Scotland
15	9	Letter	62	5.5.98	Talkative and informative	2 hours	Callander	Own home	GRMH	1958	Haddington, Callander	GP unit District nurse/ midwife

16	102	Personal request	74	22.6.98 29.7.99	Very forthcoming	1 ½ hours	Leven, Fife	Own home	GRMH	1947	Cresswell, Dumfries Forth Park, Kirkcaldy	Hospital midwife, teaching, management CMB member
17	88	Personal request	mid-40s	23.6.98	Talkative	2 hours	Falkirk	In office at work	Stirling RI and Falkirk and District RI	1981	Stirling RI	Postnatal, Lectures to St Mids on psychiatry
18	87	Personal request	41	26.6.98	Very interested, articulate	1 ½ hours	Kirkcaldy	Own home	Forth Park, Kirkcaldy	1981	Forth Park, Kirkcaldy	In Mat Unit
19	47	Nephew phoned	96	29.6.98 18.7.98	Keen to talk. A little confused	1 hour, next interview, 1 hour	Stonehaven	In hospital	Small Mat Hosp in Edinburgh	1928	HQ, Armstrong Nursing Home, Aberdeen, cases widespread	Private on district, & nursing homes
20	85	Personal request	40s	2.9.98	Very interested Used interview to tell about a bad time	1 hour	Scotland	In office at work	Not to be made public	1977	Somewhere in Scotland	In Maternity Unit
21	91	Personal request	68	3.9.98	Full of information	1 ½ hours x 2	Bannockburn	Own home	Lennox Castle	1952	Clackmannanshire, Stirling	Queen's Nurse, hospital midwife, clinical teacher
22	50	Phone call	90	12.11.98	Formal but happy to talk	1 ½ hours	Kirkcaldy	Own home	GRMH	1934	Did not practise	N/A
23	99	Personal request	90	2.8.99 3.8.99	Not v happy with recorder Int no 2 more relaxed	1 ½ hours x2	Isle of Harris	In sitting room of Home	Montrose Maternity Hospital, Govan	1939	Central Scotland, Harris, Inverness	Queen's Nurse



24	89	Contact/phone	74	6.9.99	Friendly and helpful	1 ½ hours	Killlearn	Own home	GRMH	1952 Direct entry	Many areas	Private maternity work
25	105	Contact/letter	Mid-70s	4.10.99 28.10.99	Articulate and helpful	1 ¼ hours	Peebles	Own home	England	1955 History taken from 1969	Wales, Edinburgh, Borders, Scottish Office	Sister midwife, Matron SMMP, Chief Area Nursing Officer Borders, Chief Nursing Officer Scottish Office CMB member
26	101	Contact/letter	83	13.10.99	Very willing to tell story	1 ½ hours	Mintlaw, Aberdeenshire	Own home	Uncertified Howdie	N/A	Aberdeenshire	In peoples' homes
27	93	Contact /phone	78	4.11.99	Relaxed off tape but very hesitant for a lot of the tape. Eager to help	1 ½ hours	Millport, Isle of Cumbrae	Own home	Southern General Hospital	1946	Glasgow	Duke St Hospital, Queen Mother's Hospital Community
28	110	Contact/phone	99	5.11.99	Talkative Slightly confused	¾ hour	Dalgaty Bay, Fife	In daughter's home	Uncertified Howdie	N/A	Castle Douglas area	In peoples' homes
29	94	Contact/phone	52	15.11.99	Forthcoming Int with no 112	1 ¼ hours	Aberdeen	Own home	Aberdeen Maternity Hospital	1969	Aberdeen	Hospital, GP clinic, community.
30	112	Introduced by no 94	52	15.11.99	Forthcoming Int with no 94	1 ¼ hours	Aberdeen	In home of no 94	P1 England P2- Redlands, Glasgow	1969	Campbeltown, GP unit Aberdeen	Hospital Hospital -day care.

31	35	Letter	80	2.2.00	Friendly	1 ¼ hours	Comrie, Perthshire	Own home	SMMP	1946	Leith and surrounding area	District
32	95	Contact/letter/ phone	53	7.2.00	Helpful, friendly, relaxed	1 ¼ hours	Melrose	In office at work	Aberdeen Maternity Hospital	1970	Aberdeen, Edinburgh, Borders	Hospital, Midwifery management
33	86	Intro at conference	59	18.2.00	Willing to help Forthcoming	1 hour	Edinburgh	In conference centre	Stobhill	1961	Belvedere GP Unit, Stobhill, Oban	Hospital x2, and community team
34	109	Contact/phone	82	17.3.00	Very helpful	1 hour	Edinburgh	Own home	Edinburgh, SMMP	1944	Edinburgh, England x2, Aberdeen, Edinburgh	Hospital midwife teaching, management, RCM
35	27	Letter	75	23.3.00	Very helpful Detailed	1 ¾ hours	Tillicoultry	Own home	Southern General, Glasgow	1947	Glasgow  Lanarkshire	District – Green Lady for 5 years Nursing officer District
36	108	Contact/phone	81	29.3.00 9.3.01	Articulate, keen to be interviewed	1 ¾ hours (Inter- viewed with no 114) 2 <sup>nd</sup> interview alone 1 hour	Lochgelly	Own home	SMMP	1941	Edinburgh, Fife	Hospital, community, as Triple duty, teaching
37	114	Introduced by No 108	86	29.3.00	Very hesitant to begin with Once relaxed, better	1 ¾ hours (Interviewed with No 108)	Lochgelly	In sitting room of No 108	Dunferm- line	1945	Cowden- beath and area	District Nurse/midwife
38	117	Met at RCM AGM 2000	b 1933	15.6.00	Agreed to be interviewed with support of no 119 Very good once started	1 ½ hours (Interviewed with no 119)	Paisley	In sitting room of no 119	Stobhill, Glasgow	1955	Islay, Duns, Glasgow	Private nurse and midwife. Staff mid at GRMH, Green Lady (on district)

39	119	Contact via no 117	b 1931	15.6.00	Very happy to talk Sometimes slightly mixed up	1 ½ hours (Interviewed with no 117)	Paisley	Own home	Barrshaw Hospital, Paisley	1955	Glasgow	Green Lady (on district)
40	116	Introduced by friend	b 1933	20.6.00	Very able to talk	1 ¾ hours	Near Dundee	Own home	Dundee Royal infirmary	1953	Maryfield Hospital, Dundee, DRI and Whitfield, Dundee	Hospital midwife Community midwife
41	120	Introduced by another midwife unable to be interviewed	b 1938	10.7.00	Very articulate,	1 ¼ hours	Glasgow	In office of Hospice in Glasgow Interview-ee's choice	London	1961	Stobhill Hospital SMMP,	Hospital midwife, Midwife teacher, Director of Studies, CMB member
42	69	Wrote in response to letter in newspaper	62	20.7.00	Articulate Very informative	2 hours	Letham, Angus	Own home	Nottingham	1962	Nottingham, Kirkcaldy, Angus	Hospital midwife, Senior Nursing officer for Angus covering seven hospitals, incl 3 Mat Hospitals.
43	70	Introduced by no 69	81	20.7.00	Very apprehensive to begin with	2 hours	Letham, Angus	In home of no 69	Dundee RI	1942	Angus: Froickheim and Carmyllie	As district nurse/midwife in Angus
44	125	Contacted via the Centre for the History of Medicine	80s	15.2.02	Very keen to tell life story	2 hours	Troon, Ayrshire	Own home	Robroyston, Glasgow	1946	Glasgow and Perthshire	Hospital and community
45	128	Response to letter in newspaper	85	1.8.02	Very keen to speak and be recorded.	1 ¼ hours	Wishaw, Lanarkshire	Own home	Southern General Hospital, Glasgow	1943	Lanarkshire	Nursery Sister, Nurse teaching.

## Appendix 5

### The changing place of birth in Scotland 1900-2000 : % of births at home

Year	% Births at home
Early 20 <sup>th</sup> C	95
>1930	75 <sup>1</sup>
1935	67 <sup>2</sup>
1946	48 <sup>3</sup>
1948	44 <sup>4</sup>
1949	39 <sup>5</sup>
1950	36 <sup>6</sup>
1951	33 <sup>7</sup>
1952	32
1953	31
1954	30.6 <sup>8</sup>
1955	30 <sup>9</sup>
1957	29
1960	26.5 <sup>10</sup>
1961	25 <sup>11</sup>
1965	15.4 <sup>12</sup>
1968	7 <sup>13</sup>
1969	6.4 <sup>14</sup>
1970	4.7 <sup>15</sup>
1971	3.36 <sup>16</sup>
1975	1.0 <sup>17</sup>
1980	0.5 <sup>18</sup>
1981	0.5 <sup>19</sup>
1985	0.6
1990	0.6
1995	0.8
1998	0.9
1999	0.9
2000	0.9

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- <sup>1</sup> T Murphy-Black, 'Care in the community during the postnatal period', S. Robinson and A M Thomson, eds, Midwives, Research and Childbirth, Vol.3, (Chapman and Hall: London and Glasgow, 1994), p 121.
  - <sup>2</sup> H P Tait, Vital Statistics, from I Duguid, MTD, Teaching Notes, 1955.
  - <sup>3</sup> G Cumberlege, Maternity in Great Britain (London: Oxford University Press 1948), p 53.
  - <sup>4</sup> H Tait, 'Maternity and Child Welfare', in G McLachlan, ed, Improving the Common Weal, p 420.
  - <sup>5</sup> Statistical information extracted from the Montgomery Report, Appendix III, p 56.
  - <sup>6</sup> T Murphy-Black, 'Care in the community during the postnatal period', S Robinson and A M Thomson, eds, Midwives, Research and Childbirth, Vol.3, (Chapman and Hall: London and Glasgow, 1994), p 123.
  - <sup>7</sup> Montgomery Report, Appendix III.
  - <sup>8</sup> H P Tait, Vital Statistics, from I Duguid, Teaching Notes, 1955.
  - <sup>9</sup> Montgomery Report, Appendix III.
  - <sup>10</sup> SHHD, Shared Care in Obstetrics, (Edinburgh: HMSO, 1983)
  - <sup>11</sup> SHHD, A Report on an Enquiry into Maternal Deaths in Scotland 1965-1971, (Edinburgh: HMSO, 1974), p 14.
  - <sup>12</sup> SHHD, Provision of Maternity Services in Scotland: A Policy Review (Edinburgh: HMSO 1993), p 11.
  - <sup>13</sup> A Grant, 'Intranatal care in hospital', Nursing Mirror, 1 August, 1969, pp 18-19.
  - <sup>14</sup> GRO (Scotland).
  - <sup>15</sup> Policy Review, p 11.
  - <sup>16</sup> GRO (Scotland).
  - <sup>17</sup> Tait, 'Maternity and Child Welfare', in McLachlan, ed, Improving the Common Weal, p 420.
  - <sup>18</sup> T Murphy-Black, 'Care in the community during the postnatal period', p 123.
  - <sup>19</sup> GRO (Scotland)

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